NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

GUIDANCE DOCUMENT

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Neb. Rev. Stat. § 84-901.03

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DEPT. OF HEALTH AND HUMAN SERVICES

Indian Health Service (IHS) and Tribal 638 Provider Bulletin

Eligible Providers / Provider Requirements

To participate in Nebraska Medicaid, IHS and Tribal 638 facilities[1] need to follow all applicable participation requirements outlined in 471 NAC 2 and 3. If the requirements outlined in 471 NAC 2 and 3 differ from those in 471 NAC 11, IHS and Tribal 638 providers should follow the requirements outlined in 471 NAC 11. Nebraska Medicaid accepts IHS and Tribal 638 facilities as Nebraska Medicaid providers on the same basis as other qualified providers.

To receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) **must** be enrolled with Nebraska Medicaid.

Provider Type	Licensure Requirements
Individual IHS/Tribal Providers	Individual staff members and/or providers at IHS and Tribal 638 facilities must be licensed in another state if they are not licensed in Nebraska.
IHS/Tribal Facilities	Do not have to be licensed in Nebraska but must still meet all applicable standards for licensure by the Nebraska Department of Health and Human Services (DHHS), Division of Public Health.

All provider enrollment and agreement coordination is handled through Maximus. For more information on provider enrollment, visit Nebraska Medicaid's Provider Screening and Enrollment webpage.

Eligible Recipients

For detailed regulatory information about Nebraska Medicaid eligibility, including eligibility requirements, categories, and other related processes, see Title 477 of the Nebraska Administrative Code (NAC). For additional information about Nebraska Medicaid applications and eligibility, visit Nebraska Medicaid's Medicaid Eligibility webpage.

Providers are responsible for checking a recipient's Nebraska Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using the Nebraska Medicaid Eligibility System (NMES).

[1] As authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. 93-638

Cost Sharing Provisions

American Indians and Alaska Natives don't pay premiums, copayments, coinsurance, or deductibles under Nebraska Medicaid.

This does not exclude American Indians and Alaska Natives from having to contribute toward and pay for share of cost programs, also known as spend-down programs. For such programs, expenses are paid as a part of meeting eligibility requirements.

Share of Cost Programs

Individuals with incomes too high for traditional Nebraska Medicaid can sometimes qualify for Nebraska Medicaid benefits through a share of cost program. Through these programs a beneficiary's medical expenses can be counted against their income, allowing them to qualify for benefits that they otherwise would not be eligible for.

In some cases, a spend-down (or share of cost) is required to be paid before an individual is eligible to receive Nebraska Medicaid. Individuals who receive long-term care services are also required to pay a share of cost toward their monthly services.

Dual Eligibility

Beneficiaries who are enrolled in both Medicare and Nebraska Medicaid are known as dually eligible beneficiaries, and there are several different dual eligibility categories. A full dual is “someone with full Nebraska Medicaid benefits” who is also enrolled in Medicare. For someone to have full Nebraska Medicaid benefits, they must meet all eligibility requirements (e.g., income, citizenship, age, etc.) for a Nebraska Medicaid category that provides medical benefits under the Nebraska Medicaid state plan. In addition to these medical benefits under Nebraska Medicaid, fully dual beneficiaries are also enrolled in a Medicare Savings Program (MSP).

Medicare Savings Programs (MSP) are programs that assist low-income Medicare beneficiaries with some or all of their Medicare Part A and/or B expenses. Enrollment in MSPs is dependent on the income and resource limits of individuals already enrolled in Medicare Part A and/or B. Enrollment in Nebraska Medicaid categories is dependent on eligibility criteria defined in the Nebraska Medicaid state plan. Some dually eligible beneficiaries may be enrolled in Medicare Part A and/or Part B, while not eligible for medical benefits under the Nebraska Medicaid state plan. However, they can still be considered dually eligible due to enrollment in an MSP, wherein they qualify for Nebraska Medicaid to help pay for Medicare premiums and out-of-pocket medical expenses (i.e., cost sharing: deductibles, coinsurance, and copayments).

For a comprehensive list of the federal Medicare Savings Programs (MSP), and how these overlap with full dual eligibility, see the following document from CMS: Dually Eligible Individuals – Categories.

Operationally in Nebraska, Nebraska Medicaid has its own terminology and categorization around dual eligibility which has been brought about by the Medicaid and Long-Term Care (MLTC) program’s structure and different systems limitations. All dual eligible beneficiaries in Nebraska would fall under Medicaid and Long-Term Care (MLTC) Aged, Blind, and Disabled (ABD), or non-MAGI programs. Resource and income limits for these individuals can be found outlined in the ‘Nebraska Medicaid Income Levels, Federal Poverty Levels, and Resources’ Guidance Document (DOC00544). For specific questions about the state’s categorization of dual eligibility groups, please reach out to the Medicaid and Long-Term Care (MLTC) Tribal Liaison(s).

Application and Enrollment

To apply for benefits individuals can:

- Fill out an application online at iServe;
- Call one of the numbers below to apply over the phone or to request a paper application. Phone lines are open from 8:00 a.m. to 5:00 p.m. Monday through Friday;
    - (855) 632-7633
    - In Lincoln: (402) 473-7000
    - In Omaha: (402) 595-1178

  Visit a local DHHS office.

Beneficiaries already enrolled in Nebraska Medicaid can manage their benefits through ACCESSNebraska.

One Nebraska Medicaid ID card is issued to all beneficiaries enrolled in Nebraska Medicaid, including those who are also enrolled in the Heritage Health managed care program. The card is **not** proof of eligibility but can be used by providers to verify beneficiary eligibility. Beneficiaries enrolled in managed care will also receive another separate managed care-specific member ID card in the welcome packet they receive from their managed care organization (MCO).

Covered Services

In addition to the limitation and requirements outlined in 471 NAC 11, IHS and Tribal 638 providers shall follow all applicable limitations outlined in 471 NAC 1 - 3, and all requirements outlined in each applicable service-specific chapter in Title 471 of the Nebraska Administrative Code (NAC).

Encounter Services

Qualifying encounters for services provided by IHS and Tribal 638 facilities are covered and reimbursed at the most current IHS encounter rate when medically necessary. This rate is published annually by IHS in the Federal Register. To qualify as an encounter, a service must be provided in a “face-to-face” visit between an approved healthcare practitioner and a Medicaid-eligible individual who can receive services at an IHS/Tribal 638 facility. Services appropriately provided via telehealth are considered “face-to-face” visits.

A qualifying practitioner visit covered under the scope of an encounter includes a “face-to-face” visit where covered Nebraska Medicaid services are provided by any of the following qualifying healthcare providers:

- Physician, doctor of osteopathy (DO), physician assistant (PA), nurse practitioner (NP), or certified nurse midwife (CNM);
- Dentist;
- Optometrist;
- Podiatrist;
- Chiropractor;
- Speech, audiology, physical or occupational therapist (OT);
- Mental health provider such as a psychologist, psychiatrist, licensed mental health practitioner (LMHP), certified drug and alcohol counselor, or a certified nurse practitioner (NP) providing psychotherapy or substance abuse counseling or other treatment with family and group therapy; or,
- Pharmacist.

Encounter Restrictions

Encounter Scenario	Explanation
Diagnostic services provided during a patient's visit to the IHS/Tribal 638 facility – such as radiology services, laboratory tests, and blood draws	Diagnostic services are included in the encounter and are not separately billable. ***Exception:*** if one of these services are the only services provided to the beneficiary during their visit, the service could be billed as an encounter. For example, the facility could bill the encounter rate for a beneficiary who comes into the facility for lab work ordered by a qualifying provider.
Supplies used in conjunction with a visit – such as dressings, sutures, etc.	Included in the encounter and are not separately billable.
Medications used in conjunction with an encounter – such as an antibiotic injection	Included in the encounter and are not separately billable.
Prescribed drugs dispensed as a part of an inpatient encounter	Included in the encounter and are not separately billable.
Services provided by registered nurses	Included in the encounter and are not separately billable.
Services ordered by a qualifying provider but administered by a registered nurse	Could be billed as an encounter if those are the only services provided to the beneficiary during their visit.
Vaccines/vaccine administration	Included in the encounter and is not separately billable. ***Exception:*** if this is the only service provided to the beneficiary during their visit, the service could be billed as an encounter.
Pharmacy Encounter	One pharmacy encounter per day per beneficiary is reimbursable. For example, the first covered outpatient prescription drug submitted to Nebraska Medicaid will pay the established encounter rate. Any subsequent outpatient pharmacy claims submitted for the same recipient with the same date of service will approve and pay $0. Nebraska Medicaid will audit claims for appropriate billing practices.
Professional services and facility fees	Both are included in the reimbursement of an outpatient encounter and must not be separately billed to Nebraska Medicaid

Multiple Encounters

Visits with more than one health professional, and multiple visits with the same health professional, that take place during the same day within the IHS/Tribal facility constitute a single encounter.

Exceptions to this limit are described below. Distinctly different diagnoses are typically determined based upon the primary diagnosis code.

However, distinctly different services provided to the beneficiary by different qualifying provider types for the same primary diagnosis code may still be reimbursed as multiple encounters. For example, beneficiary visits to a licensed mental health practitioner (LMHP) and psychiatrist in the same day would be reimbursed as two separate encounters, since the scope and type of services provided by the two providers are distinctly different.

Multiple Encounter Exception	Example
When the beneficiary is seen in the clinic, or by a heath professional, more than once in a 24-hour period for distinctly different diagnosis. Documentation must include unrelated diagnosis codes. **Note**: Distinctly different services provided to the beneficiary by different qualifying provider types for the same primary diagnosis code may still be reimbursed as multiple encounters. Documentation must include distinctly different service codes.	For example, a beneficiary visit to their primary care provider and a chiropractic visit on the same day would be reimbursed as two separate encounters since these services are distinctly different. **Note (Example)**: Beneficiary visits to a licensed mental health practitioner (LMHP) and psychiatrist on the same day would be reimbursed as two separate encounters, since the scope and type of services provided by the two providers are distinctly different.
When the beneficiary must return to the clinic for an emergency or urgent care situation after the first encounter that requires additional diagnosis or treatment.	For example, if a beneficiary visits their primary care provider for a checkup in the morning and returns to the facility later in the afternoon to treat a broken limb, these two visits would be reimbursed as two separate encounters.
When a beneficiary requires a pharmacy encounter in addition to a medical health professional or mental health encounter on the same day. Nebraska Medicaid covers only one pharmacy encounter per day.	For example, a beneficiary visit to their primary care provider and a covered outpatient prescription that occurs on the same day would be reimbursed as two separate encounters.
When the patient is seen in the clinic by a mental health provider (see above) for a mental health encounter in addition to a medical health professional encounter on the same day.	For example, a beneficiary visit to their primary care provider and a visit with their psychiatrist that occur on the same day would be reimbursed as two separate encounters.

Telehealth Services

IHS and Tribal 638 facilities are allowed to bill and be reimbursed at the IHS encounter rate for services appropriately provided via telehealth. Providers must also meet all other applicable requirements around billing and reimbursement for telehealth services as required by Nebraska Medicaid and as outlined in state regulation, including utilizing all applicable procedure codes and required modifiers.

Non-Encounter Services

Services that do not meet the criteria for an encounter or that are outside of the scope of an IHS/Tribal 638 Facility are not reimbursed at the encounter rate. Pharmacy services that are not provided by a designated tribal pharmacy or pharmacist are not reimbursed at the encounter rate. And services provided to non-American Indian or non-Alaska Native beneficiaries are not reimbursed at the encounter rate. Examples of non-encounter services include but are not limited to: home health services, ambulatory services, non-emergency medical transportation services, and durable medical equipment.

Out-of-State Services

Nebraska Medicaid covers services rendered to beneficiaries when appropriately licensed providers participating in the Nebraska Medicaid program administer services.

Non-Covered Services

Providers should refer to Section 3 of the Nebraska State Plan and Title 471 of the Nebraska Administrative Code (NAC) to determine whether services are covered by Nebraska Medicaid.

Billing and Payment

Claims/Billing Instructions

IHS and Tribal 638 providers should comply with all billing requirements outlined in 471 NAC 3. If requirements outlined in 471 NAC 3 differ from those in 471 NAC 11, IHS and Tribal 638 providers should follow the requirements outlined in 471 NAC 11. IHS and Tribal 638 providers are required to follow all applicable billing instructions outlined in Appendix 471-000-62.

Facility Type	Claims Form
Hospital-based Facilities	Submit all claims for services provided to beneficiaries on the Form CMS-1450 For an example of the Form CMS-1450, see Appendix 471-000-51 For instructions and requirements regarding completing the Form CMS-1450, see Appendix 471-000-78
Non-hospital-based Providers	Submit all claims using the appropriate claim form or electronic format, as outlined in the Claim Submission Table in Appendix 477-000-49

All claims billed at the encounter rate must be billed using the 'T1015' encounter rate code. Claims billed at the encounter rate using a CMS-1450 (Institutional) or CMS-1500 (Professional) claim form must also include the 'SE' modifier. Claims billed at the encounter rate using an ADA (Dental) form should not include any additional modifiers. Appropriate billing and diagnosis codes for all services included in the encounter should be included on the claim and billed under the T1015 code.

Reimbursement

Nebraska Medicaid will reimburse IHS and Tribal 638 providers for services provided in accordance with the applicable payment regulations outlined in 471 NAC 3. If payment regulations in 471 NAC 3 differ from those in 471 NAC Chapter 11, IHS and Tribal 638 providers should follow payment regulations outlined in 471 NAC 11.

IHS and Tribal 638 facilities will be paid at the most current IHS encounter rate for qualifying encounter services (as outlined in 471 NAC 11) provided by the facility that are otherwise covered under the Nebraska Medicaid State Plan. All qualifying encounters, except for inpatient hospital encounters, are reimbursed at the outpatient encounter rate. Inpatient hospital encounters are reimbursed at the inpatient encounter rate.

To receive the inpatient hospital per diem rate, the IHS or Tribal 638 facility must:

- Be enrolled as a provider with Nebraska Medicaid; and
- Appear on the IHS maintained listing of IHS-operated facilities and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

Encounter rate changes are effective the first day of the month following the Department's notice of the encounter rate posted by IHS in the federal register and will be applied retroactively to the federal effective date.

IHS/Tribal 638 providers may provide services outside of those that qualify as an encounter. Services covered under the Nebraska Medicaid State Plan, but not considered eligible for encounter reimbursement, should be billed on Form CMS-1500 using the appropriate HCPCS codes. These services will be paid according to the applicable Nebraska Medicaid Provider Rates and Fee Schedules.

Dental Billing and Reimbursement

All dental services provided by IHS and Tribal 638 facilities that qualify as an encounter (i.e., are appropriately provided by a dentist at the clinic/facility) are to be billed at the IHS encounter rate using the T1015 encounter rate code and should include dental service-specific CDT code(s) on the subsequent line(s) for dental services that were completed on the date of service. All dental services provided by IHS and Tribal 638 facilities that qualify as an encounter are reimbursed at the IHS encounter rate. This includes dental services where the Nebraska Medicaid Fee Schedule rate is higher than the IHS encounter rate. It also includes services where the Nebraska Medicaid Fee Schedule rate is lower than the IHS encounter rate – all qualifying dental encounter services provided are billed and reimbursed at the IHS encounter rate.

Denture and Other Multi-Visit Services

For denture and other multi-visit services, the prior authorization request submitted by the IHS/Tribal 638 facility should specify the number of visits being requested for the service. As part of their authorization review process, the MCOs will work with IHS and Tribal 638 facilities to ensure an appropriate number of visits are captured in the prior authorization. If additional visits beyond the standard number of visits for the service are needed, the MCOs can set the prior authorization units accordingly. Additional visits beyond the number approved in the initial prior authorization, or beyond the standard number of visits for the service, must be requested by the IHS/Tribal 638 facility and require approval to ensure medical necessity.

IHS and Tribal 638 facilities would then bill for each visit at the IHS encounter rate using the T1015 encounter rate code and should include the dental service-specific CDT code(s) on the subsequent line(s). Each visit for the approved denture or multi-visit services (as approved in the service prior authorization request) would be billed using the same service-specific code(s) and reimbursed at the IHS encounter rate.

Contracted Services

IHS and Tribal 638 facilities can contract with non-IHS/Tribal 638 providers to provide covered services, including qualifying encounter services, to American Indian and Alaska Native (AI/AN) beneficiaries. In these cases, all contracted non-IHS/Tribal providers must be enrolled as providers with Nebraska Medicaid and are required to affiliate as a provider with the IHS/Tribal 638 facility. Covered services would then be billed under the IHS/Tribal 638 facility, with the contracted provider listed as the service rendering provider (SRP), and appropriate reimbursement would be made to the IHS/Tribal 638 facility.

Services Provided "Outside of the Four Walls"

The Centers for Medicare & Medicaid Services (CMS) published a final rule which finalized the Medicaid Clinic Services Four Walls Exceptions.[2] As part of the Medicaid clinic services[3] benefit under 42 CFR § 440.90, the final rule requires coverage of services furnished outside of an IHS or Tribal 638 clinic by clinic personnel under the direction of a physician. Nebraska Medicaid covers the clinic services benefit and therefore is required to cover and reimburse for these services provided outside of an IHS or Tribal 638 clinic (also referred to as being provided "outside of the four walls"). The final rule also authorizes the Medicaid program to reimburse IHS and Tribal 638 clinics for services provided outside of the four walls at the facility-based clinic services payment rate which, as noted above, is the most current IHS encounter rate for qualifying encounter services or the appropriate Nebraska Medicaid Fee Schedule rate for non-encounter services.

Unless otherwise specified, all provisions, limitations, and requirements outlined in this Guidance Document apply to services provided outside of the four walls.

Billing

When billing for services provided outside of the clinic, IHS and Tribal 638 clinics must utilize the applicable Place of Service (POS) code and include billing documentation (including a narrative when appropriate) which accurately reflects and describes the place where services were appropriately delivered. The billing location would be the IHS/Tribal clinic. Claims for services provided outside of the clinic must indicate the service rendering provider (SRP).

Reimbursement

Qualifying services appropriately provided outside of the IHS/Tribal 638 clinic which meet the definition of an encounter under 471 NAC 11 will be reimbursed at the most current IHS encounter rate.

Policy governing reimbursement for multiple encounters would not change based on where the services are provided. If qualifying encounter services that are 'distinctly different' (based on primary diagnosis code) are appropriately provided by the IHS/Tribal 638 clinic, they are to be reimbursed as multiple encounters regardless of whether those services are provided inside or outside of the facility.

Any service appropriately provided by the IHS/Tribal 638 clinic outside of the clinic which does not meet the definition of an encounter under 471 NAC 11 would be reimbursed according to the Nebraska Medicaid Fee Schedule. Services that cannot be appropriately provided outside the clinic would not be considered for reimbursement when performed outside of the clinic.

[2] Per the final rule, the effective date of the Medicaid Clinic Services Four Walls Exception for IHS/Tribal facilities is January 1, 2025

[3] Clinic services are defined by Section 1905(a)(9) and at 42 CFR 440.90 and they include preventative, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not a part of a hospital but is organized and operated to provide medical care to outpatients.

Provider Requirements

Provider requirements would not differ for services provided within or outside of the clinic. All providers rendering services would need to be enrolled with Nebraska Medicaid and be affiliated with the billing IHS/Tribal 638 clinic's enrolled provider number. Individual IHS/Tribal 638 providers must be licensed in another state if they are not licensed in Nebraska.

Covered services, including qualifying encounter services, provided outside of the four walls by a non-IHS/Tribal 638 providers contracted and affiliated with an IHS or Tribal 638 clinic would be billed under the IHS/Tribal 638 clinic with the contracted provider listed as the service rendering provider (SRP) using the appropriate Place of Service (POS) code and documentation to note that the services were provided at the contracted provider's location.

Urban Indian Organizations

Urban Indian Organizations (UIOs) are not reimbursed at the federal IHS encounter rate. However, all Urban Indian health facilities in Nebraska are enrolled as federally qualified health centers (FQHCs), and thus are reimbursed under the FQHC services benefit, and not the clinic services benefit. There is no federal four walls requirement for FQHCs, and federal Medicaid law does not prevent states from covering Medicaid FQHC services provided outside of the four walls of an FQHC. As such, these Urban Indian health facilities could provide, and be reimbursed for, services that are appropriately provided outside of their facility. These services would be reimbursed at their applicable rate listed in the Nebraska Medicaid Fee Schedule.

Place of Service Codes

When billing for services, IHS and Tribal 638 facilities must use the applicable Place of Service (POS) code which accurately reflects where services are appropriately delivered. Examples include, but are not limited to, a clinic office (POS 11), a mobile unit (POS 15), a school (POS 03), someone's home (POS 12), a homeless shelter (POS 04), etc. For services provided outside of the four walls, the POS code must accurately reflect the setting in which the services were provided.

Documentation Requirements

Providers must keep medical and financial records that fully justify and disclose the extent of services provided and billed to Nebraska Medicaid in accordance with Provider Bulletin 21-10. Records must be retained for at least 6 years after the last date a claim was paid or denied. Medical records must clearly reflect when multiple encounters occurred and that these were medically necessary.

Timely Filing

Nebraska Medicaid must receive a provider's completed claim form within 6 months following the date the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by Nebraska Medicaid in certain circumstances.

Third-Party Liability

Nebraska Medicaid beneficiaries may have one or more additional sources of coverage for health services. Nebraska Medicaid is generally the payer of last resort, meaning Nebraska Medicaid only pays for a service if there are no other liable third-party payers, or pays after other liable third-party payers as applicable. Providers must pursue the availability of third-party payment sources and should reference state regulations and the CMS 'Coordination of Benefits and Third-Party Liability in Medicaid' instructions when applicable.

Third-Party Liability is defined in 471 NAC 3 as, “Any individual, entity, or program which is, or may be, contractually or legally liable to pay all or part of the cost of any medical service furnished to an individual.” After receiving third-party liability payment for a claim, IHS/Tribal 638 providers may bill Nebraska Medicaid or the MCOs to be reimbursed for the remaining amount up to the applicable encounter rate for qualifying encounter services, or the applicable fee schedule rate for non-qualifying encounters, provided to Nebraska Medicaid-eligible beneficiaries (See 471 NAC 3.005.05).

Crossover Claims

In the case of fully dual eligible beneficiaries (e.g. those enrolled in an MSP and eligible for Nebraska Medicaid benefits), for services billed on Medicare crossover claims which also qualify as an encounter under Nebraska Medicaid, Medicare reimburses the provider first, and Nebraska Medicaid is required to pay for the remainder of the costs, up to the encounter rate (if Medicare’s payment is less than the encounter rate amount).

However, for all other Medicare crossover claims for dually eligible beneficiaries who are not eligible for medical benefits under Nebraska Medicaid, these claims would not qualify as an encounter under Nebraska Medicaid, and thus would not be eligible for reimbursement at the IHS encounter rate. In these instances, Nebraska Medicaid is only required to make a payment to providers on Medicare crossover claims if the Nebraska Medicaid rate for the service provided exceeds the Medicare paid amount. When this is the case, Nebraska Medicaid either pays the difference between the Medicare payment and the Nebraska Medicaid rate or the Medicare cost sharing amount, whichever is less. This is also referred to as the “lesser-of” payment methodology. For more information about the Medicare crossover claims payment methodology in Medicaid and Long-Term Care’s (MLTC) state plan, see Supplement 1 to Attachment 4.19-B Pages 1-3.