471-000-409 Nebraska Medicaid Fee Schedule for Ambulatory Surgical Center Rates

Payment for services as outlined in this fee schedule shall be made as outlined in 471 NAC 26.

The five-digit numeric codes included in the Schedule are obtained from the Physicians' Current Procedural Terminology (CPT®). CPT® is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. This Schedule includes CPT® numeric identifying codes for reporting medical services and procedures.

The Schedule includes only CPT® numeric identifying codes for reporting medical services and procedures that were selected by the Nebraska Department of Health and Human Services, State of Nebraska. Any user of CPT® outside the Schedule should refer to CPT®. This publication contains the complete and most current listings of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures.

HCPCS procedure codes are defined by the Centers for Medicare and Medicaid Services (CMS). For HCPCS procedure code definitions, refer to the CMS website at http://cms.hhs.gov/. HCPCS procedure code manuals are also available through private vendors.

Providers may notice a minor difference between the published payment amount on the fee schedule and the actual payment amount. The payment system uses seven decimal places in the reimbursement calculation, but the fee schedule publishes only the first two decimal places.

The Nebraska Medicaid Maximum Allowable Ambulatory Surgical Center Group Rates are listed below.

ASC Group	Rate (Effective July 1, 2021)
1	$393
2	$526
3	$607
4	$747
5	$848
6	$959 ($809+$150 for IOLs)
7	$1174
8	$1133 ($983+$150 for IOLs)
9	$1583

IOL=Intraocular Lens Allowance

For billing instructions for Ambulatory Surgical Center (ASC) Services, see http://dhhs.ne.gov/Documents/471-000-62.pdf

TO DETERMINE THE FEE SCHEDULE ALLOWABLE:

1. LOCATE THE PROCEDURE CODE. Procedure codes are listed numerically. The online PDF format has a search feature which will bring you directly to the code you wish to view.
2. The dollar amount listed is the fee schedule allowable. No further calculations are required.
3. PAYMENT IS THE LOWER OF THE FEE SCHEDULE ALLOWABLE OR THE PROVIDER'S SUBMITTED CHARGE. The provider's submitted charge must reflect their charge to the general public.

Prior Authorization (PA) – Certain service require prior authorization as indicated by an "X" in the PA column. If PA is required, see 471 NAC 18 regarding the PA procedure: http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-18.pdf
An authorization request may be faxed to 402-471-9092 to Attn: Physical Health Services Unit or E-Fax to 402-742-1104. The authorization decision will be faxed back to the requesting provider. Claims submitted without the required prior authorization will not be reimbursed for the procedure. If the client is covered under a Medicaid Managed Care Plan, please obtain such authorizations directly through that plan.

For more information on ACS, see the Nebraska Medicaid policy 471-NAC 26-000: http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-26.pdf

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