

471-000-505 NEBRASKA MEDICAID PRACTITIONER FEE SCHEDULE FOR CHIROPRACTIC SERVICES

Payment for services as outlined in this fee schedule shall be made as outlined in 471 NAC 5.

PLEASE NOTE: RATES DO NOT REFLECT AN INCREASE FROM THE PREVIOUS FEE SCHEDULE AS THERE WERE NO RATE INCREASE APPROPRIATIONS FOR THIS STATE FISCAL YEAR

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.

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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.

No codes, fee schedules, basic unit values, relative value guides, guidelines, conversion factors or scales are included in any part of CPT. The AMA assumes no liability for the data contained herein.

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TREATMENT LIMITATIONS:

1. For clients aged 21 and older, chiropractic treatment is limited to those treatments deemed medically necessary;
2. For clients aged 20 and younger, chiropractic treatment is limited to those treatments deemed medically necessary; and
3. No more than one treatment per client per day is covered.

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 following guidelines outline the maximum number of treatments Nebraska Medicaid may consider for payment:

http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-05.pdf

Requirements to Provide Telehealth Services

Follow Applicable Laws and Regulations

- Health care practitioners providing telehealth services must follow all applicable state and federal laws and regulations their practice and the services they provide.
- The provider must ensure telehealth services can be delivered safely and effectively.
- The provider must be enrolled with Nebraska Medicaid and must be licensed in the state where the client is located.
- All treatments or services submitted for reimbursement must be delivered by existing service definitions.
- All treatments and services are expected to be rendered in a clinically appropriate manner and be medically necessary and related to the treatment plan.

Keep Required Documentation

- The provider must obtain informed consent before the initial telehealth visit and annually thereafter. The written consent becomes a part of the client's medical record. See 471 NAC 1 § 004.04.
- The medical record for telehealth services must follow all applicable statutes and regulations on documentation. The use of telehealth technology must be documented in the medical record.
- Providers are expected to document the rationale for the delivery of treatment or services through telehealth.
- Providers are expected to have mitigation plans in place and to provide an active and ongoing assessment of their ability to meet patients' most immediate and critical treatment needs.

Understand Unique Requirements

- Any service requiring hands-on interaction to meet the service definition should not be provided through telehealth.
- The location of the telehealth service is identified by the physical location of the client. Out-of-State telehealth services are covered if the telehealth services otherwise meet the regulatory requirements for payment for services provided outside Nebraska. Coverage includes both when the client is in Nebraska while the practitioner is in another state and instances in which the client is in another state, regardless of where the practitioner is located.
- Telehealth services are intended to improve members' access to services by addressing barriers to receiving quality care.

Billing Telehealth

To bill for services administered through telehealth, please use the following Place of Service codes and Modifiers. See 471 NAC 1 § 004.04 for more information on telehealth.

Place of Service codes:

- Place of Service 02 – use when telehealth is administered while the patient is in a location besides their home.
- Place of Service 10 – use when telehealth is administered while the patient is in their home.

Modifiers:

- Multiple modifiers can be added to a single CPT code. The payment modifier goes first, followed by any informational modifiers.
- The telehealth modifier is an informational modifier and should be placed after any payment modifier.

Telehealth Modifiers and Definitions

93 - Synchronous Telemedicine Service rendered via telephone or other real-time interactive audio-only telecommunication system

95 - Telehealth services are provided in real-time with an audio-visual component

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Follow Applicable Laws and Regulations

- Health care practitioners providing telehealth services must follow all applicable state and federal laws and regulations governing their practice and the services they provide.
- The provider must ensure telehealth services can be delivered safely and effectively.
- The provider must be enrolled with Nebraska Medicaid and must be licensed in the state where the individual is located.
- All treatments or services submitted for reimbursement must be delivered by existing service definitions.
- All treatments and services are expected to be rendered in a clinically appropriate manner and be medically necessary and/or related to the treatment plan.

Keep Required Documentation

- The provider must obtain informed consent before the initial telehealth visit and annually thereafter. The written consent form becomes a part of the individual's medical record. See 471 NAC 1 § 004.04.
- The medical record for telehealth services must follow all applicable statutes and regulations on documentation. The use of telehealth technology must be documented in the medical record.
- Providers are expected to document the rationale for the delivery of treatment or services through telehealth.
- Providers are expected to have mitigation plans in place and to provide an active and ongoing assessment of their ability to meet patients' most immediate and critical treatment needs.

Understand Unique Requirements

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- Telehealth services are intended to improve members' access to services by addressing barriers to receiving quality care.

Billing Telehealth

To bill for services administered through telehealth, please use the following Place of Service codes and Modifiers. See 471-1-004 for more information on telehealth.

Place of Service Codes

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.

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