471-000-518 Nebraska Medicaid Practitioner Fee Schedule for Physician Services

Payment for services as outlined in this fee schedule shall be made as outlined in 471 NAC 18.

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.

Nebraska Medicaid payment is the lower of the fee schedule maximum allowable, the provider's submitted charge, or when applicable, invoice cost. The provider's submitted charge must reflect their charge to the general public. The dollar amount listed is the fee schedule allowable. No further calculations are required.

Further instructions for the Practitioner Fee Schedule includes:

1. SPECIAL PRICING

    A. "BR" (By Report): Procedures denoted BR (by report) in the unit value column indicate a variance in procedure too great to establish a relative value. These procedures must be justified by submitting a report, which references the procedure, when submitting claims. Those claims that include a supply must also have an invoice for the supply. Upon review, reimbursement is paid at a reasonable rate.

B. “RNE” (Relative Value Not Established): Procedures denoted “RNE” in the unit value column indicates a procedure which is new or uncommon. These procedures must be justified by submitting a report with the claim that references the procedure. Upon review, reimbursement is paid at a reasonable rate.

C. "IC" (Invoice Cost) - Paid at invoice cost. An invoice copy must be submitted. When billing for supplies used during the course of a clinic visit, all HCPCS codes require an invoice. If the invoice includes several items, circle the item you are billing for. Some of these services may also have an associated maximum allowable and will be reimbursed at the lower of invoice cost or maximum allowable.

D. “MP noted in Medicaid allowable column indicates “manual pricing”.

DOCUMENTATION REQUIREMENTS

1. All unlisted procedures require documentation to identify the service performed. Usually an operative/procedural report will be adequate documentation.

2. Billing for 2 visits during one encounter with the same provider (e.g. preventative visit and E/M visit) requires documentation to support significant additional work in addition to the preventative visit.

3. Hospital rounds are paid once per day unless documentation regarding a change in condition requiring another visit is submitted.

4. Multiple outpatient E/M (office, ER, etc.) visits with same provider/same day; documentation may be indicated to clarify the time of each visit.

5. Multiple providers in same group following patient in the hospital – would require documentation of different specialties for providers (e.g. pediatric neurologist, pediatric pulmonologist).

ADDITIONAL FEATURES OF THE FEE SCHEDULE

1. Prior Authorization (PA) – Certain services require prior authorizations as indicated by an “X” in the PA column. If PA is required, see 471 NAC 18 for guidance.
   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 individual is covered under a Medicaid Managed Care Plan, please obtain such authorizations directly through that plan.

2. Comments column – comments may be placed in this column to denote such items as, but is not limited to, requirements for reimbursement or if the procedure is obsolete and not covered.

3. Code coverage – check columns to see if the procedure is covered by Medicaid (denoted by the dollar amount listed in the non-facility/facility rate columns). If appropriate, cross reference from a non-covered code to a payable code that is used for the service.

INFORMATION

Injectables and Clinical Lab: Fee Schedules are located at:
http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx
Injectable vaccine codes are denoted INJ in the pricing column on the Practitioner Fee Schedule for physician services.

For more information on Physician Services, see the Nebraska Medicaid policy 471 NAC 18 Physicians'Services:http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-18.pdf

Reimbursement for services provided by physicians and non-physician care providers is subject to the site-of-service payment adjustment. Nebraska Medicaid applies a site of service differential that reduces the fee schedule amount for specific CPT/HCPCS codes when the service is provided in the outpatient setting. Based on the Medicare differential, Nebraska Medicaid will reimburse specific CPT/HCPCS codes with adjusted rates based on the site of service.

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 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

• 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 individual. 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 individual is in Nebraska while the practitioner is in another state and instances in which the individual 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 471-1-004 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 telecommunications system

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