

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.

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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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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.

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.

- 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 client 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.

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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 & 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.

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