

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OTHER LABORATORY AND X-RAY SERVICES

Anatomical Laboratory Services

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for anatomical laboratory services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician or Clinical Laboratory Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
 - a. The unit value multiplied by the conversion factor;
 - b. The invoice cost (indicated as "IC" in the fee schedule);
 - c. The maximum allowable dollar amount; or
 - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).
When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2024, and are effective for anatomical laboratory services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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Clinical Diagnostic Laboratory Services

Clinical diagnostic laboratory services, including collection of laboratory specimens by venipuncture or catheterization, is paid based on the fee schedule determined by Medicare.

The fee schedule amounts for Clinical Laboratory services are based on 100% Medicare Clinical Laboratory Fee Schedule. The Department shall update the Clinical Laboratory fee schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

X-Ray Services

For dates of service on or after August 1, 1989, Nebraska Medicaid pays a claim for both the technical and professional components of x-ray services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
 - a. The unit value multiplied by the conversion factor;
 - b. The invoice cost (indicated as "IC" in the fee schedule);
 - c. The maximum allowable dollar amount; or
 - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year. Updates are adjusted based on the Medicare fee schedule.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2024, and are effective for radiology services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

Payment for the professional component only provided to hospital inpatient or outpatient is made according to the Nebraska Medicaid Practitioner Fee Schedule, not to exceed 40 percent of the payment for the total component, as allowed under the fee schedule, for the service provided in a non-hospital setting.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

Transmission costs are not covered when transmission time is negligible. Transmission time is negligible in instances such as, but not limited to, the store and forward transmission of data sent for professional review and interpretation. Transmission time less than 5 minutes for a telehealth service is deemed negligible for Medicaid payment purposes.

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