

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

CLINIC SERVICES

Nebraska Medicaid pays for clinic services and outpatient mental health services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Mental Health and Substance Use 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 Mental Health and Substance Use 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 clinic 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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RURAL EMERGENCY HOSPITAL (REH) CLINICS:

Payment for Services Furnished by a REH

The outpatient rate is the ancillary and outpatient service cost center's cost-to-charge ratio up to 100%.

Out-of-State REH Rates

Outpatient rates will be the average of in-state rural emergency hospitals.

Payment for Certified Registered Nurse Anesthetist (CRNA) Fees:

A certified registered nurse anesthetist (CRNA) provider may choose to retain their billing privileges and submit claims directly for certified registered nurse anesthetist charges, which would follow the anesthesia fee schedule. The REH may also elect one of the following two options to bill for certified registered nurse anesthetist professional fees on behalf of the certified registered nurse anesthetist provider. Certified registered nurse anesthetist providers in either circumstance must reassign billing privileges to the REH. In cases when Medicare is the primary payer, the provider must follow Medicare billing requirements. In either option below, the certified registered nurse anesthetist provider must not separately bill for charges that occurred in the REH for which they have reassigned billing privileges:

- (A) The REH may choose to bill on a professional claim form for outpatient certified registered nurse anesthetist services. Reimbursement will follow the Nebraska Medicaid anesthesia fee schedule; or
- (B) The REH may bill on an institutional claim form for outpatient professional certified registered nurse anesthetist costs using revenue code 964 (certified registered nurse anesthetist professional fees). Reimbursement will be based on REH outpatient applicable rates.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Payment for Psychiatric Day Treatment Services: Payment rates for psychiatric day treatment services for individuals age 19 and older will be on a unit basis. Rates are set annually for the period July 1 through June 30. Rates are set prospectively for this period and are not adjusted during the rate period. Providers are required to report their costs on an annual basis. Providers desiring to enter the program who have not previously reported their costs or that are newly operated are to submit a budgeted cost report, estimating their anticipated annual costs.

Providers shall submit cost and statistical data on the required form based on the timeframes in 471 NAC 20-003.08. Providers shall compile data based on generally accepted accounting principles and the actual method of accounting based on the provider's fiscal year. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. If the provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will inform the provider via letter that no further payment will be made until a proper cost report is filed. In setting payment rates, the Department will consider those costs which are reasonable and necessary for the active treatment of the clients being served. Such costs will include those necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care requirements, and discharge planning. The Department does not guarantee that all costs will be reimbursed. The cost reporting document is used by the Department only as a guide in the rate setting process. Actual costs incurred by the providers may not be entirely reimbursed.

Psychiatric day treatment centers operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation, excluding educational services. State-operated centers will receive an interim payment rate, with an adjustment to actual costs following the cost reporting period.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Payment for Telehealth Services: Payment for telehealth services is included in the cost basis used to set the Medicaid rate.

Health care practitioner services included in a per diem, per monthly, or DRG rate may be provided by telehealth technologies when they otherwise meet the requirements set forth in state regulations, as amended. These services are included in the appropriate cost reports or other accounting data used to calculate the rate.

Payment for Telehealth Transmission Costs: Telehealth transmission costs are allowable costs when they otherwise meet the requirements set forth in state regulations, as amended. These costs are included in the appropriate cost reports or other accounting data used to calculate the rate.

The Department covers transmission costs for the 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 audio-visual transmission as set forth in state regulations, as amended.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Ambulatory Surgical Centers:

Payment of facility fees for services provided in an ambulatory surgical center (both free-standing and hospital-affiliated) is made at the rate established by Medicaid for the appropriate group of procedures.

If one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate. If more than one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate for the procedure with the highest rate. NMAP pays for other covered ambulatory surgical procedures performed in the same operative session at 50 percent of the applicable group rate for each procedure.

Insertion of intraocular lens prosthesis with cataract extraction is considered two procedures; payment is made at 150 percent of the applicable group rate. If this procedure is performed bilaterally, payment is made at 150 percent of the group rate for the first procedure (first eye) and 100 percent for the second procedure (second eye).

The ambulatory surgical center may also provide services which are not directly related to the performance of a surgical procedure, such as durable medical equipment, medical supplies, and ambulance services. Payment for these services will be made according to the methods and standards elsewhere in the Title XIX Plan for the appropriate service.

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 charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for the 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 audio-visual transmission as set forth in state regulations, as amended.

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Pediatric Feeding Disorder Clinic Intensive Day Treatment: Reimbursement for pediatric feeding disorder clinic intensive day treatment for medically necessary services will be a bundled rate based on the sum of the fee schedule amounts for covered services provided by Medicaid enrolled licensed practitioners. This service is reimbursed via a daily rate.

Pediatric Feeding Disorder Clinic Outpatient Treatment: Reimbursement for Pediatric Feeding Disorder Clinic Outpatient Treatment for medically necessary services will be based on the appropriate fee schedule amount for a physician consultation. This service is reimbursed via an encounter rate.

An encounter means a face-to-face visit between a Medicaid-eligible patient and a physician, psychologist, speech therapist, physical therapist, or dietician during which services are rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of pediatric feeding disorder services. The agency's fee schedule rate was set as of July 1, 2024 and is effective for pediatric feeding disorder services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the Pediatric Feeding Clinics' fee schedule for the specific program and year.

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