

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS – MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES
SUITABLE FOR USE IN THE HOME

Nebraska Medicaid covers the purchase or rental of durable medical equipment, medical supplies that meet program guidelines when prescribed by a physician or other licensed practitioner whose licensure allows prescribing these items. To qualify as a covered service under Nebraska Medicaid, the item must be medically necessary and provided in accordance with 42 CFR 440.70.

Nebraska Medicaid does not cover items that primarily serve personal comfort; convenience; or educational, hygienic, safety, or cosmetic functions; or new equipment of unproven value and/or equipment of questionable current usefulness or therapeutic value.

Home health agencies may provide durable medical equipment and oxygen only.

Durable medical equipment and supplies providers shall complete and sign the Medical Assistance Provider Agreement, and submit the completed form to the Department for approval. Providers shall meet any applicable state and federal laws governing the provision of their services. Nebraska Medicaid enrolls, as providers of durable medical equipment, medical supplies, or orthotics, only those providers who are involved in the direct provision of services or items to the client.

Durable medical equipment is equipment which:

1. Withstands repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an illness or injury; and
4. Is appropriate for use in the beneficiary's home. This generally does not include long term care facilities.

For initial order a face-to-face encounter must occur within six months before or 30 days after the durable medical equipment, orthotics, and medical supplies order is written.

Nebraska Medicaid became compliant with the Electronic Visit Verification System (EVV) requirements for home health services on February 1, 2024, in accordance with section 12006 of the 21st Century CURES Act.

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Supersedes

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Effective Date July 1, 2024

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NMAP covers medical supplies listed in the coverage criteria and procedure code list when prescribed for medical care in the client's home. Items not specifically listed may not be covered by NMAP. Coverage for medical supplies does not generally include clients residing in nursing facilities or ICF/MR's.

NMAP does not cover, as medical supplies, personal care items such as non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, contact solutions, etc. NMAP does not cover, as medical supplies, oral or injectable over-the-counter drugs and medications.

NMAP covers orthotic devices when medically necessary and prescribed to support a weak or deformed body member or restrict or eliminate motion in a diseased or injured part of the body. Coverage includes braces, orthopedic shoes and shoe corrections, lumbar supports, hernia control devices, and similar items. NMAP covers prosthetic devices when medically necessary and prescribed to replace a missing body part. Orthotics and prosthetics are covered for clients residing in nursing facilities and ICF/MR's. NMAP does not cover external powered prosthetic devices.

NMAP covers only one pair of orthopedic shoes at the time of purchase. Except when size change is necessary due to growth and/or when diagnosis indicates excessive wear, NMAP allows only one pair of shoes in a one-year period. Orthopedic shoes and shoe corrections are not covered for flexible or congenital flat feet.

Prior authorization is required of payment of rental and purchase of the items listed in state regulations as requiring prior authorization.

Telehealth: Medical equipment, supplies, orthotics and prosthetics furnished by durable medical equipment suppliers and pharmacies are not covered when provided via telehealth technologies.

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The State assures that with respect to an individual applicant's request for an item of medical equipment (ME) that the following conditions are met:

1. The process is timely and employs reasonable and specific criteria by which an individual item of Medical Equipment (ME) will be judged for coverage under the state's home health services benefit. These criteria must be sufficiently specific to permit a determination of whether an item of ME that does not appear on a state's pre-approved list has been arbitrarily excluded from coverage based solely on a diagnosis, type of illness, or condition.
2. The state's process and criteria, as well as the state's list of pre-approved items, are made available to beneficiaries and the public.
3. Beneficiaries are informed of their right, under 42 CFR. Part 431 Subpart E, to a fair hearing.

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