

CHAPTER 3-000 PAYMENT FOR MEDICAID SERVICES

3-001 Definitions:

Claim means a request for payment for services rendered or supplied by a provider to a client.

Clearinghouse means an entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction and receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard or nonstandard data content for the receiving entity.

HCPCS means the Healthcare Common Procedure Coding System. This contains the national codes adopted by the federal Secretary of Health and Human Services and includes American Medical Association's Current Procedural Terminology (CPT) Level I procedure codes and Level 2 procedure codes.

Indian means an individual, defined at 25 U.S.C. sections 1603(c), 1603(f), and 1679(b), or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization—I/T/U) or through referral under Contract Health Services.

Indian Health Care Provider means a health care program, including contract health services, operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined 25 U.S.C. 1603

Standard Transaction means an electronic transaction that complies with the applicable standard adopted under federal law.

Transaction means the exchange of information between two parties to carry out financial or administrative activities related to health care.

Trading Partner Agreement (TPA) means an agreement related to the electronic exchange of information.

Warrant means a paper check or electronic funds transfer.

3-002 Approval and Payment

3-002.01 Approval: Payment for medical care and services through NMAP funds must be approved by the Department. Claims will be approved for payment when all of the following conditions are met:

1. A provider agreement is on file with the Department, as well as the certification and transmittal from the state licensing agency or the Centers for Medicare and Medicaid Services (CMS) Regional Office when required;
2. The client was eligible for NMAP when the service was provided, or the service was provided during the period of retroactive eligibility;
3. No more than 12 months have elapsed from the date of service when the claim is received by the Department (see 471 NAC 3-002.01A for exceptions);

3-008 Copayments

3-008.01 Copayment Schedule: The Department has established the following schedule of copayments for Medicaid services, effective ~~January 1, 1995~~ October 1, 2011.

Service	Amount of copayment
Chiropractic Office Visits	\$1 per visit
Dental Services.....	\$3 per specified service
Drugs	\$2 per prescription
Durable Medical Equipment	<u>\$3 per specified service</u>
<u>Drugs (except birth control)</u>	
<u>Generic drugs</u>	<u>\$2 copay</u>
<u>Brand Name drugs.....</u>	<u>\$3 copay</u>
Eyeglasses.....	<u>\$2 per frames, lens, or frames with lens-dispensing fee</u>
Hearing Aids	\$3 per <u>hearing aid-dispensing fee</u>
<u>Inpatient Hospital</u>	<u>\$15 per admission</u>
<u>Mental Health/Substance Abuse Visits</u>	<u>\$2 per specified service</u>
Occupational Therapy (non-hospital based)	\$1 per specified service
Optometric Office Visits	\$2 per visit
Outpatient Hospital Services	\$3 per visit
Physical Therapy (non-hospital based)	\$1 per specified service
Physicians (M.D.'s and D.O.'s) Office Visits	\$2 per visit
(Excluding Primary Care Physicians Family Practice, General Practice, Pediatricians, Internists, and physician extenders {including physician assistants, nurse practitioners, and nurse midwives} <u>who providing primary care services</u>)	
Podiatrists Office Visits.....	\$1 per visit
Speech Therapy (non-hospital based)	\$2 per specified service

Note: See 471-000-126 for a list of procedure codes for the services that are subject to copayment requirements. Drug products exempted from the copayment requirements are indicated on the Department's Drug Name/License Number Listing microfiche.

3-008.01A Excluded Services: The following services are excluded from the above copayment requirement by federal regulations:

1. Emergency services provided to treat an emergency medical condition in a hospital, clinic, office or other facility that is equipped to provide the required care. An emergency condition is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including but not limited to, severe pain, that a prudent lay person possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person (or with respect to a pregnant woman, the health of the woman and her unborn child) afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person.
2. Family planning services, supplies, and drugs (such as contraceptive pills, creams, lotions etc.) provided to individuals of child-bearing age; and
3. Services provided by a health maintenance organization (HMO) to individuals enrolled in the HMO.

3-008.02 Covered Persons: All Medicaid-eligible adults age 19 or older listed below are subject to the copayment requirement:

1. Adults eligible under the Aid to Dependent Children (ADC) program;
2. Adults eligible under the Aid to Aged, Blind, and Disabled (AABD) program;
3. Adults eligible under the Refugee Resettlement Program (RRP);
4. Individuals who are receiving extended assistance for former Department wards; and
5. Individuals age 19 and 20 eligible under the Ribicoff program.

The client's Medicaid eligibility document will indicate whether the client is subject to the copayment requirement. The provider may also verify the client's copayment status by contacting the Nebraska Medicaid Eligibility System (NMES) or by using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) (see 471-000-50 Electronic Transactions Instruction).

3-008.02A Change in Client's Copayment Status During the Month: The client's copayment status may change during the month. If the client's copayment status changes during the month (for example, admission to a medical institution or alternate care as defined in 471 NAC 3-008.02B, or verification of pregnancy), the provider may submit documentation regarding copayments made or collected erroneously and the Department will make the appropriate adjustments to the claim. The provider shall refund the client (either cash or credit) when a copayment is erroneously collected. Providers may contact the Nebraska Medicaid Eligibility System (NMES) or use the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) to verify the client's copayment status.

3-008.02B Exempted Persons: The following individuals are exempted from the copayment requirement:

1. Individuals age 18 or younger;
2. Pregnant women through the immediate postpartum period (the immediate postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends);
3. Any individual who is an inpatient in a hospital, long term care facility (NF or ICF/MR), or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for personal needs for medical care costs;
4. Individuals residing in alternate care, which is defined as domiciliaries, residential care facilities, centers for the developmentally disabled, and adult family homes; and
5. Indians who receive items and/or services furnished directly by an Indian Health Care Provider or through referral from an Indian Health Care Provider under contract health services.