

10-003.05F5b Clinical Lab Services: Clinical laboratory services provided to hospital inpatients, outpatients, and non-patients are routinely performed by non-physicians (i.e., medical technologists or laboratory technicians) manually or using automated laboratory equipment. These clinical laboratory services do not require performance by a physician and are considered a technical component; there is no professional component for these services. The technical component must be billed as described in 471 NAC 10-003.05F1. Payment is made to the hospital as follows:

1. Inpatient Services: Payment is included in the hospital's payment for inpatient services. The hospital may include these costs on its cost report to be considered in calculating the hospital's payment rate;
2. Outpatient Services: Payment is made ~~according to~~ at 97.5% of the fee schedule determined by CMS (see 471-000-520);
Note: Outpatient clinical laboratory services must be itemized on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate HCPCS procedure codes (see 471 NAC 10-010.06).
3. Non-Patient Services: Payment is made ~~according to~~ at 97.5% of the fee schedule determined by CMS. (See 471-000-520)

There is no separate payment made to the pathologist for routine clinical lab services. To be paid, the pathologist must negotiate with the hospital to arrange a salary/compensation agreement.

10-003.05F5c Leased Departments: Leased department status has no bearing on billing or payment for clinical lab services. The hospital shall claim all clinical lab services, whether performed in a leased or non-leased department. Payment for the total service (professional and technical component) is made to the hospital. The Department does not make separate payment for the professional component for clinical lab services.

10-003.05F5d Anatomical Pathology Services: Anatomical pathology services are services which ordinarily require a physician's interpretation. If these services are provided to hospital inpatients or outpatients, the professional and technical components must be separately identified for billing and payment.

10-010.06 Payment for Outpatient Hospital and Emergency Room Services: For services provided on or after July 1, 2010, the Department pays for outpatient hospital and emergency services with a rate which is the product of:

1. Seventy five (75) percent of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form CMS-2552-89, Pub. 15-II, Worksheet C); multiplied by
2. The hospital's submitted charges on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The effective date of the cost-to-charges ratio is the first day of the month following the Department's receipt of the cost report.

Providers shall bill outpatient hospital and emergency room services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services ~~on~~ at 97.5% of the fee schedule determined by CMS. ~~See 471 NAC 10-003.04C3h. See 471-000-520.~~

10-010.06A Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: Effective for cost reporting periods beginning after July 1, 1999, payment for outpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. NMAP will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory or radiology services, that were previously paid for under those methods. Payment for these and other outpatient services will be made in accordance with reasonable cost principles. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility's provider number. To avoid any interruption of payment, NMAP will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

10-010.06B Payment to Hospital-Affiliated Ambulatory Surgical Centers: The Department pays for services provided in an HAASC according to 471 NAC 10-010.06, Payment for Outpatient Hospital and Emergency Room Services, unless the HAASC is a Medicare-participating ambulatory surgical center (ASC). If the HAASC is a Medicare-participating ASC, payment is made according to 471 NAC 26-005.

10-010.06C Payment for Outpatient Mental Health and Substance Abuse Services in a Hospital: Providers shall use HCPCS procedure codes when submitting claims to the Department for Medicaid services. These codes are defined by the Health Care Common Procedure Coding System (HCPCS). These five-digit codes and two-digit modifiers are divided into two levels:

18-004.29A Physician's Office Laboratory: A laboratory which a physician or a group of physicians maintains for performing diagnostic tests in connection with his/her own or the group practice is not considered an independent clinical laboratory.

If the services are provided in a physician's or group of physician's private office, payment may be claimed for the medically necessary services provided or supervised by the physician(s), using the appropriate HCPCS procedure code.

Payment for tests obtained in the physician's office but sent to an independent clinical lab or hospital for processing must be claimed by the facility performing the tests, using the appropriate HCPCS procedure code. The private physician's office may be reimbursed for the collection by venipuncture or catheterization for these procedures by using the appropriate HCPCS procedure code at the providers' submitted charge up to ~~the maximum allowed~~ 97.5% of under the Medicare clinical laboratory fee schedule (see 471-000-520). The Department does not reimburse the private physician(s) for processing or interpreting tests performed outside his/her office.

18-004.29B Licensed/Certified Independent Clinical Laboratories: An independent clinical laboratory must have a separate provider agreement with the Department (see 471 NAC 18-001.02).

A radiological laboratory is not considered an "independent laboratory" under NMAP. An independent clinical laboratory is one which is independent both of an attending or consulting physician's office and of a hospital. A consulting physician is one whose services include history taking, examination of the patient and, in each case, furnishing to the attending physician an opinion regarding diagnosis or treatment. A physician providing clinical laboratory services for patients of other physicians is not considered a consulting physician.

A laboratory which is operated by or under the supervision of a hospital (or the organized medical staff of the hospital) which does not meet the definition of a hospital is considered to be an independent laboratory. However, a laboratory serving hospital inpatients and outpatients and operated on the premises of a hospital which meets the definition of a hospital is presumed to be subject to the supervision of the hospital or its organized medical staff and is not classified as an independent clinical laboratory. The hospital's certification covers the services performed in this laboratory.

Exception: If an anatomical pathology specimen is obtained from a hospital outpatient and is referred to an independent lab or the pathologist of a second hospital's laboratory, the independent lab or the pathologist of a second hospital's laboratory to which the specimen was referred may claim payment for the total service (professional and technical components) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.33E6 Billing and Payment for Non-Patient Anatomical Pathology Services: A non-patient is an individual receiving services who is neither an inpatient nor an outpatient. For specimens from non-patients referred to the hospital, the hospital shall bill the total service (both professional and technical components) on the appropriate institutional claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.066 ff.

18-004.33E7 Leased Departments: If the pathology department is leased and an anatomical pathology service is provided to a hospital non-patient, the pathologist shall claim the total service (professional and technical components) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

Leased department status has no bearing on billing for or payment of inpatient or outpatient anatomical pathology services.

18-004.33E8 Clinical Lab Services: The professional and technical components of clinical lab services are not separately identified for billing and payment. Clinical lab services provided to inpatients, outpatients, and non-patients of a hospital are claimed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made to the hospital as follows:

1. Inpatient Services: Payment is included in hospital's prospective payment rate.
2. Outpatient Services: Payment is made according to the fee schedule determined by CMS Medicaid.
3. Non-Patient Services: Payment is made according to the fee schedule determined by CMS Medicaid.

There is no separate payment made to the pathologist for routine clinical lab services. To be paid, the pathologist must negotiate with the hospital to arrange a salary/compensation agreement.

18-004.33E9 Physician's Office or Independent Lab: Clinical lab services performed in a physician's office or independent lab must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is based on the ~~Medicare national~~ Medicaid fee schedule for clinical laboratory services to cover the total service (professional and technical components). (See 471-000-520).

18-006 Payment for Physician Services: The Nebraska Medical Assistance Program (NMAP) pays for covered physician services, except clinical 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 Practitioner 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 Medical Services Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).
3. Exception: The Director of the Division of Medicaid and Long-Term Care or designee may enter into an agreement with an out-of-state provider for a rate that exceeds the rate according to the Nebraska Medicaid Practitioner Fee Schedule only when the Medical Director of the Division has determined that:
 - a. The client requires specialized services that are not available in Nebraska; and
 - b. No other source of the specialized service can be found.

Reimbursement for services provided by physicians and non-physician care providers is subject to the site-of-service payment adjustment. NMAP applies a site of service differential that reduces the fee schedule amount for specific CPT/HCPCS codes when the service is provided in a facility setting. Based on the Medicare differential, NMAP will reimburse specific CPT/HCPCS codes with adjusted rates based on the site of service. For the list of applicable CPT/HCPCS codes, refer to NAC 471-000-541.

Payment for clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization is made at 97.5% of the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare. (See 471-000-520).

HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-518).

18-006.01 Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
 - a. Not appropriate for the service provided; or
 - b. Based on errors in data or calculation.

Providers will be notified of the revisions and their effective dates.

19-004 Payment for Podiatry Services: The Nebraska Medical Assistance Program (NMAP) pays for covered podiatry services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner 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;
 - d. For clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization, 97.5% of the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare; or
 - e. 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).

19-004.01 Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure which was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
 - a. Not appropriate for the service provided; or
 - b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

19-004.02 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see 471 NAC 3-004.

19-004.03 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008.

19-005 Billing Requirements: Podiatrists shall bill the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The provider or the provider's authorized agent shall submit the provider's usual and customary charge for each procedure code listed on the claim.

19-005.01 Procedure Codes for Podiatry Services: Podiatrists shall use the appropriate CPT or HCPCS procedure codes when billing NMAP.

HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-519).

24-003.07 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Medicaid Division.

24-004 Payment for Visual Care Services: The Nebraska Medical Assistance Program (NMAP) pays for covered visual care services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner 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) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
 - c. The maximum allowable dollar amount;
 - d. For clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization, 97.5% of the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare; or
 - e. 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).

24-004.01 Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure which was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
 - a. Not appropriate for the service provided; or
 - b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

33-002.07 Payment for HEALTH CHECK (EPSDT) Services: The Nebraska Medical Assistance Program (NMAP) pays for covered HEALTH CHECK services, except for clinical laboratory services or when provided under capitated contract for EPSDT participants enrolled in capitated plans, at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule 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;
 - 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).

Payment for clinical laboratory services is made at 97.5% of the amount allowed for each procedure code in the fee schedule for clinical laboratory services as established by Medicare.

The Department reserves the right to adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
 - a. Not appropriate for the service provided; or
 - b. Based on errors in data or calculation.

Providers will be notified of the revisions and their effective dates.

33-002.08 Billing Requirements: Providers shall bill NMAP on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) for HEALTH CHECK (EPSDT) exams, HEALTH CHECK-associated services, and other comparable exams. See the Claim Submission Table at 471-000-49.

Note: Providers are to bill all well-baby, well-child exams, and comparable examinations as HEALTH CHECK examinations.

The physician or the physician's authorized agent shall submit the physician's usual and customary charge for each procedure code listed on or in the claim.