

18-004.26 Family Planning Services: ~~NMAP~~ Nebraska Medicaid covers family planning services, including consultation and procedures, provided upon the request of the client. Family planning services and information must be provided to clients without regard to age, sex, or marital status, and must include medical, social, and educational services. The client must be allowed to exercise freedom of choice in choosing a method of family planning. Family planning services performed in family planning clinics must be prescribed by a physician, and furnished, directed, or supervised by a physician or registered nurse.

Covered services for family planning include initial physical examination and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services, and prescribing medication for specific treatment.

18-004.27 Fracture Care: Initial fracture care includes the application and removal of the first cast or traction device. Providers may claim subsequent replacement of cast and/or traction devices used during or after the period of follow-up care as an independent service using the appropriate HCPCS procedure code.

18-004.28 Practitioner-Administered Medications: The Department will reimburse practitioner-administered injectable medications at ~~95 percent of~~ the Medicare Drug Fee Schedule rate, plus an administration fee as listed. Injectable medications approved by the Medicaid Medical Director but not included on the Medicare Drug Fee Schedule will be reimbursed at the ~~wholesale acquisition cost (WAC) plus 6.8 percent estimated acquisition cost (EAC) used to reimburse pharmacy claims~~. When billing for medications administered during the course of a clinic visit, the physician must use the appropriate HCPCS procedure code for the medication, the correct number of units per the HCPCS description, the National/Drug Code (NDC) of the drug administered, the NDC 'unit of measure' and the number NDC units. A CPT code for the administration must also be submitted.

When billing for medication that does not have a specific Level I or II code, the physician must use a miscellaneous HCPCS code with the name and NDC number identifying the drug and include the dosage given. If this information is not with the claim, the Department may return the claim to the physician for completion or pay the claim at the lowest dosage manufactured for the specific drug. Payment for service is as described in 18-006 and 18-006.01.

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 97.5 percent of the Medicare clinical laboratory fee schedule (see 471-000-520). Payment for service is as described in 18-006 and 18-006.01.~~ 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 Medicaid~~. 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.

18-006 Payment for Physician Services: ~~The Nebraska Medical Assistance Program (Medicaid)~~ Medicaid 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 Medicaid 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. Medicaid 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, Medicaid 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 the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare. [The Fee Schedule may be revised in accordance with 18-006.01.](#)

Non-Payment of Other Provider Preventable Conditions (OPPCs): Effective on or after the effective date of this regulation for physician and non-physician provider claims, payment will be denied for the following OPPCs:

1. Wrong surgical or other invasive procedure performed on a patient;
2. Wrong surgical or other invasive procedure performed on the wrong body part;
3. Wrong surgical or other invasive procedure performed on the wrong patient.

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

19-004 Payment for Podiatry Services: ~~The Nebraska Medical Assistance Program (NMAP)~~ Medicaid 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 percent of~~ at 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 Medicaid](#).

HCPCS/CPT procedure codes used by [NMAP Medicaid](#) 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 ~~Medicaid 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 ~~Medicaid 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 percent of the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare;~~ or
 - de. 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)~~ Medicaid 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 percent of~~ at 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~~ Medicaid 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 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 submit the physician's usual and customary charge for each procedure code listed on or in the claim.