CHAPTER 16-000 PHARMACY SERVICES

16-001 Standards for Participation: A provider of pharmacy services shall be a licensed pharmacy, licensed pharmacist, or dispensing physician. To participate in the Nebraska Medical Assistance Program (NMAP), the provider shall fully meet the standards established by the Department of Health and Human Services and any applicable state and federal laws or regulations governing the provision of the service. Providers shall meet all the Department's pharmacy regulations contained in this chapter.

The pharmacy provider shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit it to the Department to be approved for provider enrollment. Approval may be denied or withdrawn at the discretion of the Director.

16-001.01 Drug Utilization Review: As a condition of participation, the provider is required to:

1. Provide prospective drug utilization review before dispensing each prescription. This shall include screening for:
   a. Therapeutic duplication;
   b. Drug disease contraindications;
   c. Drug interactions;
   d. Incorrect dosage or duration;
   e. Drug allergies; and
   f. Clinical abuse/misuse; and
2. Provide patient counseling on all matters which, in the provider's professional judgment, are deemed significant, including:
   a. Name/description of the medication;
   b. Route, dosage form, duration of therapy;
   c. Directions for use;
   d. Adverse reactions, contraindications;
   e. Storage; and
   f. Refill information; and
3. Maintain adequate patient profiles which may include:
   a. Name, address, phone number, date of birth, and gender;
   b. Individual history (i.e., diseases, allergies, drug reactions)
   c. Comprehensive listing of medications; and
   d. Relevant comments.

16-002 Covered Services: NMAP covers outpatient drugs in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (Public Law 101-508) including:

1. Legend drugs;
2. Compounded prescriptions; and
3. Over-the-counter (OTC) drugs indicated as covered on the Nebraska Point of Purchase (NE-POP) System or listed on the Department's website.

16-002.01 Compounded Prescriptions: A compounded prescription is a mixture of ingredients which the provider prepares in the pharmacy. (See the NE-POP System User's manual for billing instructions.)

Reimbursement for compounded prescriptions will be limited to those ingredients which are indicated as covered on the NE-POP System or listed on the Department's website.

Any mixture of drugs which results in a commercially available OTC preparation is not considered a compounded prescription, for example, dilute HCL, MOM with cascara, OTC hydrocortisone preparations.

16-002.02 Over-the-Counter (OTC) Drugs: NMAP covers only OTC drugs indicated as covered on the NE-POP System or listed on the Department's website. OTC drugs shall be prescribed by a licensed practitioner.

16-002.03 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 shall meet the conditions of items 1 through 6 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services shall be prior authorized by the Division of Medicaid and Long-Term Care of the Department of Health and Human Services.

16-002.04 Tobacco Cessation Counseling: In addition to a physician/mid-level practitioner, only a licensed pharmacist, meeting Department conditions of participation in 471 NAC 16-002.04A as a Tobacco Cessation Counselor, may provide tobacco cessation counseling.

16-002.04A Tobacco Cessation Counseling – Conditions of Participation: As a condition of participation as a Tobacco Cessation Counselor, the provider shall:

1. Be a licensed pharmacist;
2. Complete a Department-approved tobacco cessation counselor training;
3. Maintain current training as a Tobacco Cessation counselor as required by the Department;
4. Complete and sign a new provider agreement (Form MC-19), indicating the employing pharmacy as the "pay to" provider, and submit proof of completing the Department-required training as part of the provider agreement completion process, or upon request by the Department;

5. Provide Tobacco Cessation counseling which is separate and distinct from the prospective drug utilization review that is required in 471 NAC 16-001.01 and is not related to the dispensing of any drug product; and
6. Provide feedback to the physician/mid-level practitioner who ordered the services.

16-002.05 Prescription Refills: Prescription refills shall be performed and recorded in a manner consistent with existent State and Federal laws, rules and regulations. Automatic refills are not allowed. All prescription refills shall be initiated by a request from the prescriber, client, or other person acting as an agent of the client, i.e., family member. In the event the client is residing in a facility, a nurse or other authorized agent of the facility pursuant to a valid prescriber's order may initiate the request for refill.

16-003 Non-Covered Services: Payment by NMAP will not be approved for:

1. Requests for quantities not in compliance with 16-004.07.
2. Experimental drugs or non-FDA approved drugs;
3. Drugs or items when the prescribed use is not for a medically accepted indication;
4. Drugs or items prescribed or recommended for weight control and/or appetite suppression;
5. Liquors (any alcoholic beverage);
6. Drug Efficacy Study Implementation Program (DESI) drugs identified as Less Than Effective or Identical, Related or Similar (LTE/IRS) with an indicator value assigned by the FDA of either 5 or 6;
7. Personal care items (examples: non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, and contact solutions);
8. Medical supplies and certain drugs for nursing facility and intermediate care facility for the mentally retarded (ICF/MR) patients (see 471 NAC 7-000 and 16-004.05);
9. Over-the-counter (OTC) drugs not listed on the Department's website;
10. Drugs or items used for cosmetic purposes or hair growth;
11. Baby foods, milk substitutes or metabolic agents (Lofenalac, etc.,) normally supplied by Nebraska Department of Health and Human Services (see 471 NAC 16-002.03 for exceptions);
12. Drugs distributed or manufactured by certain drug manufacturers or labelers that have not agreed to participate in the drug rebate program;
13. Products used to promote fertility;
14. Medications dispensed as partial month fills for nursing facility or group home residents when dispensed by more than one pharmacy;
15. Medications dispensed to replace products which have been recalled by the drug manufacturer;
16. Drugs, items or products of manufacturers/labelers that are identifiable as non-covered on the NE-POP System or on the Department’s website;
17. Drugs, classes of drugs or therapeutic categories of drugs that are Medicare Part D Drugs and Medicare Part D Covered supplies or equipment, for all persons eligible for benefits under Medicare Part D, whether or not such persons are enrolled into a Medicare Part D Plan (see 471 NAC 3-004 for definitions of Medicare Part D Drugs, Medicare Part D Covered supplies and equipment, Medicare Part D and Medicare Part D plan);
18. Drugs or classes of drugs approved by the Federal Food and Drug Administration for treatment of sexual or erectile dysfunction, or drugs or classes of drugs that are being used for the treatment of sexual or erectile dysfunction. Drugs or classes of drugs that are approved by the Federal Food and Drug Administration for treatment of sexual or erectile dysfunction and for conditions other than treatment of sexual or erectile dysfunction, and are prescribed for those other conditions may be covered, but NMAP may require prior authorization. (See 471 NAC 16-004); and
19. Automatic refills. (See 471 NAC 16-002.05).

16-004 Limitations and Requirements for Certain Services

16-004.01 Prior Authorization: The Department requires that authorization be granted prior to payment for certain drugs. Should a practitioner dispense a prescription prior to the actual authorization he/she takes a business risk that payment for the prescription may be denied. Providers that are prescribing these drugs or pharmacists that are dispensing these drugs shall obtain prior authorization by submitting the request by standard electronic transaction or by phone, fax or mail, from either:

1. The Department's NE-POP contractor; or
2. The Pharmacy Consultant (or designee)
   Nebraska Department of Health and Human Services
   Division of Medicaid and Long-Term Care
   P O Box 95026
   301 Centennial Mall South, 5th Floor
   Lincoln, NE 68509-5026
   Phone: (877) 255-3092
   Fax (402) 742-2348

The NE-POP contractor or the Department will respond to any request for prior authorization within 24 hours of receipt of the request. In cases of medical emergency, provisions are made for dispensing a seventy-two (72) hour supply of a covered outpatient prescribed medication.

16-004.01A Approval Decision: The NE-POP contractor or the Department will notify the provider prescribing the drug or the pharmacy dispensing the drug if the authorization has been granted, the eligible dates of the authorization, and the identification of the provider who requested the authorization. The prior authorization is given for the drug, the client, and the prior authorization dates.

16-004.01B Denial Decision: The NE-POP contractor or the Department will notify the provider prescribing the drug or the pharmacy dispensing the drug if coverage is denied.

16-004.01C Emergency Decision: The NE-POP contractor or the Department will authorize dispensing up to a seventy-two (72) hour supply of a covered outpatient prescribed medication for cases meeting the definition of a medical emergency as outlined in 471 NAC 2-004.04A.

16-004.01D Unknown Decision: If the provider that is prescribing the drug or the pharmacy that is dispensing the drug has not received an authorization from the NE-POP contractor or the Department, payment may be denied.

16-004.01E Verifying Status of Requests: The status of prior authorization requests for drugs may be verified by the pharmacy by submitting a claim via the NE-POP System. If the prior authorization request has not been approved, the pharmacy may contact the NE-POP contractor or the Department for prior authorization.

16-004.02 Products Requiring Prior Approval: Identifiable products requiring approval prior to payment are designated as such on the NE-POP System or on the Department's website. There are three reasons for the use of prior authorization; product based controls, utilization controls and scope controls.

1. Product Based Controls. Prior authorizations that fall under this category are products where there are medically appropriate alternative treatments which are more cost-effective for the Department.
2. Utilization Controls. Prior authorizations that fall under this category generally apply to the quantity of medication or duration of therapy approved.
3. Scope Controls. Scope controls are used to ensure a drug is used for an approved or medically accepted indication, is clinically appropriate, medically necessary and cost-effective.
    a. Medications which have been approved by the FDA for multiple indications may be subject to a scope-based prior authorization when at least one of the approved indications places that drug in a therapeutic category or treatment class for which a prior authorization is required; or
    b. Prior authorization may be required to assure compliance with FDA approved and/or medically accepted indications, dosage, duration of therapy, quantity, or other appropriate use criteria including pharmacoeconomic consideration; or
    c. Prior authorization may be required for certain non-standard dosage forms of medications when the drug is available in standard dosage forms.

16-004.03 Preferred Drug List and Pharmaceutical and Therapeutics Committee

16-004.03A Preferred Drug List (PDL): The Medicaid Prescription Drug Act of 2008 requires the Department to establish and maintain a Preferred Drug List for the Medicaid program with the aid of the Pharmaceutical and Therapeutics Committee. Individual drugs will be designated as Preferred or Non-Preferred within therapeutic classes of prescribed drugs reviewed by the Pharmaceutical and Therapeutics Committee. Drugs designated as Preferred Drugs may be prescribed for Medicaid clients without prior authorization from the Department; however some Preferred Drugs may have clinical claim limits to ensure appropriate use. The Preferred Drug List and other related activities shall not be construed to replace, prohibit, or limit other lawful activities of the Department not specifically permitted or required by the Act. Drugs classified as Preferred Drugs will be eligible for Supplemental Rebates as described under the provision of 471 NAC 1-002.02M7.

The Department will include on the Preferred Drug List prescribed drugs that are found to be therapeutically equivalent to or superior to other drugs within a therapeutic class, and the net cost of the drugs are equal to or less than other drugs within a therapeutic class after consideration of applicable rebates or discounts negotiated by the Department or its designated contractor. All classes of medications shall be considered for inclusion on the PDL except the antidepressants, antipsychotics or anticonvulsant medications.

Medications designated as non-preferred on the Preferred Drug List will be subject to Prior Authorization. The Pharmaceutical and Therapeutics Committee will develop criteria for use of medications with non-preferred status.

A health care provider may prescribe a drug designated as non-preferred on the Preferred Drug List to a Medicaid client without prior authorization by the Department if the provider certifies that:

1. The client is achieving therapeutic success with a course of medication for human immunodeficiency virus, multiple sclerosis, cancer, or immunosuppressant therapy; or
2. The client has experienced a prior therapeutic failure with a medication designated as a Preferred Drug.

The Department will maintain an updated Preferred Drug List in electronic format and will make the list available to the public from the Department's website. Drugs and classes of drugs included on the PDL will be reviewed annually. Changes will be communicated to providers at least 30 days prior to implementation.

16-004.03B Pharmaceutical and Therapeutics Committee (P & T Committee): The Department will establish a Pharmaceutical and Therapeutics Committee to review certain classes of drugs for efficacy, safety and cost, for inclusion on or exclusion from the Department's Preferred Drug List. The Pharmaceutical and Therapeutics Committee will advise the Department on all matters related to the Preferred Drug List.

The members of the Pharmaceutical and Therapeutics Committee will be appointed by the Director of the Division of Medicaid and Long-Term Care. The members will meet the requirements as set forth in the Medicaid Prescription Drug Act of 2008. Members of the Committee will be reimbursed for their actual and necessary expenses.

The Pharmaceutical and Therapeutics Committee will receive and review data as reviewed and approved by the Department's Pharmacy Consultant. The data shall include information about each drug's efficacy relative to other drugs in the class being reviewed and the relative safety of each drug. After drugs or drug classes have been reviewed and their efficacy and safety determined, the net cost of each may be provided by the Department's Pharmacy Consultant to the Committee, if needed, in order to determine a Preferred Drug. The drug net cost may be provided to allow comparability, such as on the net cost per day of therapy. Drug rebates and supplemental drug rebates will be included in the drug net cost determination.

All Pharmaceutical and Therapeutics Committee meetings will be open to all interested parties. Public comments will be allowed, but may be constrained by necessity by time or other resources. The Preferred Drug List Program Coordinator shall develop an agenda for each meeting and make it available to all interested parties at least 30 days before the meeting. Pharmaceutical and Therapeutics Committee meetings or portions thereof may not be open to all interested parties if confidential material is being covered, such as Unit Rebate Amounts or Supplemental Unit Rebate Amounts.

The proceedings of each Pharmaceutical and Therapeutics Committee meeting or portion thereof that is open to the general public will be published.

16-004.04 Drug Utilization Review (DUR): The Department is authorized by federal statute to conduct a DUR program. The DUR program shall be in compliance with U.S.C., Title 42, Chapter 7, Subchapter XIX, Section 1396r – 8. The DUR program consists of prospective drug review, retrospective drug review, the application of explicit predetermined standards and an educational program. The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate and medically necessary and that they are not likely to result in adverse medical results.

The Department or the Department's contractor utilizes a DUR Board to review and analyze clinical and economic data available. The DUR Board reviews and makes recommendations based on predetermined standards submitted to them by the Department or the Department's contractor(s) and, in concert with retrospective review of claims data, makes recommendations for educational interventions, prospective DUR and the prior authorization process. The DUR Director shall develop an agenda for each meeting and make it available to all interested parties at least 30 days before the meeting. The Department or the Department's contractor may charge a reasonable fee for providing copies and mailing information to interested parties.

The Drug Use Review Board shall, upon the Department's request, review drugs or classes of drugs and make recommendations to the Department regarding drugs or classes of drugs for prior authorization. The Department makes the final decision on which drugs or classes of drugs will require prior authorization.

For those drugs that will require prior authorization, the DUR Board shall develop and recommend prior authorization criteria to the Department. The Department may accept, reject, or modify the recommended criteria.

The Department will communicate information related to prior authorization criteria on the Department's website. The DUR Board will review existing prior authorization criteria annually.

The manufacturer or any interested party may request that a drug or class of drugs on prior authorization be placed on the agenda of a DUR board meeting, but no drug or class of drugs will be placed on the DUR agenda more than once every 12 months without the consent of the DUR director, in consultation with the Department's Pharmacy Consultant. The manufacturer of the drug may request that the DUR director waive the 30-day notification rule when asking to have its product placed on the agenda.

All DUR Committee meetings will be open to all interested parties. Public comments will be allowed, but may be constrained by necessity of time or other resources. The minutes of the proceedings of each DUR Committee meeting or portion thereof that is open to the general public will be published.

16-004.05 Pharmacy Services for clients residing in certain care facilities:

16-004.05A Non-Covered Items: NMAP does not cover the following items as pharmacy services for clients residing in a Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICF/MR):

1. Hydrogen peroxide;
2. Rubbing alcohol; and
3. OTC enemas.

The NF or ICF/MR may be reimbursed for these items under the Department's payment plan for NF and ICF/MR services.

For clients residing in NFs and ICF/MRs, the Department does not cover medical supplies or durable medical equipment as pharmacy services. See 471 NAC 7-000.

16-004.05B Replacement Cost: Providers shall not duplicate medication, at the Department's expense, for clients residing in facilities. The pharmacy or the facility is responsible for providing a replacement. Providers shall not bill the Department for medication that was destroyed upon a client's discharge.

Examples of situations which are NOT to be billed to the Department include, but are not limited to, the following:

If the client's medication is:

1. Lost;
2. Broken;
3. Misplaced;
4. Not received by the facility;
5. Destroyed:
   a. During a client's temporary absence from the facility (e.g., during therapeutic leave days, bedhold period, medical/surgical days);
   b. Following a change of directions; or
   c. At any time that the medication is ordered for the client, unless the medication has expired.

16-004.05C Professional Dispensing Fees: Pharmacies providing medications to NF and ICF/MR patients are allowed one professional dispensing fee per recipient and drug per month.

16-004.05D Unit Dose:

16-004.05D1 Definitions:

Traditional bottle method: Dispensing multiple tablets and capsules in one vial or bottle. This excludes systems such as cassettes, individually packaged doses on cards containing multiple doses and all similar systems.

Unit dose is a system of drug packaging, dispensing, returning, billing and crediting by a unit dose provider.

Unit dose packaging is drug packaging approved by the Nebraska Board of Pharmacy.

Unit dose dispensing is the provision to the patient of a 14-day or less supply of a drug in unit dose packaging.

Unit dose returning is the process of returning unit dose packaged drugs to the dispensing pharmacy.

Unit dose billing is billing the Department one time per calendar month for the quantity of drug used by the patient during the month (see 471 NAC 16-004.07E for exceptions). The quantity used is the difference between the quantity dispensed and the quantity returned. (Note: See 471 NAC 16-004.05B, Replacement Cost, for examples of drugs which are NOT considered to have been used by the patient and are NOT billable to the Department). The date of service for each unit dose billing shall be consistent from month to month.

Unit dose crediting is a process of issuing credits by the pharmacy to the Department for drugs accepted for return into inventory that were previously billed to and covered by the Department.

Unit dose provider is a pharmacy approved by the Department as a unit dose provider. Initial approval is contingent upon written agreement by the provider and demonstration by the provider, to the satisfaction of the Department, of the provider's ability to use unit dose packaging, unit dose dispensing, unit dose returning, unit dose billing and unit dose crediting. Continuing approval is contingent upon the provider's actual performance as specified in the written agreement.

16-004.05D2 Reimbursement: The Department shall only reimburse unit dose providers for prescribed drugs dispensed to Medicaid clients residing in facilities. A facility may submit a written request to the Department to waive the unit dose packaging requirements for clients participating in a rehabilitation program that includes training in medication management under the traditional bottle method. If a waiver is granted, the Department will notify the facility and the pharmacy of approval of the request.

16-004.05E Drugs Returned for Credit: Providers that accept returns of dispensed drugs from long term care facilities shall credit the Department for those drugs. A drug cost level, below which credits shall not be mandatory, may be established by the Department.

16-004.06 Medical Supplies and Durable Medical Equipment: Any medical supply or durable medical equipment indicated as covered on the NE-POP System or on the Department's web- site is covered as a pharmacy service under this chapter.

16-004.07 Quantity Limitations: The Department imposes the following quantity limitations on certain drugs.

16-004.07A Payment from NMAP will not be approved for:

1) More than a 3 month supply of any maintenance medication.
2) More than a one month supply of any controlled substance.
3) More than a one month supply of any injectable medication except insulin and those injectable drugs with a duration of greater than one month from one dose.

16-004.07B Quantities: The following types of limits may be utilized to ensure appropriate utilization and billing.

a. Maximum quantity over time
b. Maximum daily dose
c. Maximum days supply per fill
d. Maximum quantity per fill
e. Minimum quantity per fill
f. Maximum cost per fill
g. Tablet splitting
h. Number of units to require medication be submitted in multiples of the package size

16-004.07C Injections: The Department applies the following limitations to injectable drug products:

1. Only those injections that are either self-administered by the client or are administered for the client at the client's place of residence are reimbursable. Injections that are administered by the provider or hospital are not reimbursable through the pharmacy services program (see 471 NAC 10-003.02 and 18-004.28);
2. Whenever available and the necessity warrants, multi-dose vials of medication shall be dispensed rather than single-dose vials or unit-dose syringes;
3. Single-dose syringes may be reimbursed at the proportionate cost of a multi-dose vial;
4. Maintenance injectable medications which are not reconstituted or admixed by the pharmacy prior to administration to the patient shall be dispensed and billed for the full month's supply;
5. Non-maintenance injectable medications and those injectable medications which must be reconstituted or admixed by the pharmacy prior to administration to the patient including subcutaneous, intramuscular, and intravenous medication delivery by large volume parenteral, piggyback, syringe pump or other methods may be provided at the pharmacist's discretion. Courses of therapy of ten days or less duration shall be billed at the end of the course of therapy. Courses of therapy of greater than ten days duration shall be billed at the end of the course of therapy or after each ten days of therapy; and
6. Injectable medications administered by implanted or similar devices may not be billed to the pharmacy services program when the device is filled in the clinic or hospital.
7. Total parenteral nutrition (TPN) shall be billed through the Durable Medical Equipment and Medical Supplies program. This includes the amino acids, carbohydrates, lipids and all additives. All TPN-compatible additives shall be billed through the supplier program regardless of who completes the addition of the ingredient or the method of administration.

16-004.07D Maintenance Drugs: The Department requires that any other maintenance drug or any drug used in a chronic manner be prescribed and dispensed in a minimum of a one-month supply.

Note: Providers shall not reduce prescriptions which are written for quantities larger than a month's supply to a month's supply. The Department considers prescription splitting to be fraudulent except when such reduction is done to comply with State or Federal regulations or statute.

16-004.07E Exceptions to Quantity Limitations: The Department allows the following exceptions to the quantity limitations of this subsection only for those clients that are receiving their medications by/through a non-unit-dose system, except where noted otherwise:

1. When the prescriber first introduces a maintenance drug to a patient's course of therapy, the prescriber may prescribe a smaller quantity as his/her judgment dictates. Pharmacists shall indicate that this is the initial filling of the medication when filing the drug claim. Any subsequent dispensing of this maintenance drug shall be prescribed and dispensed in at least a month's supply.
2. When the prescriber's professional judgment indicates that these quantities of medication are not in the patient's best medical interest, the prescriber may prescribe as his/her judgment directs. This includes limitations for lock-in clients. The pharmacist shall maintain documentation that an exception is being made to the Department's requirements.
3. The Department will consider replacement of any lost, misplaced, or stolen drug products for clients, only when the pharmacy provider or prescriber documents the conditions that require replacement. The Department will require additional information (police reports, etc.) prior to replacing controlled substances.
4. Schedule II drugs are exceptions to the quantity limitations. This also applies to unit dose systems, unless the Schedule II drug is used in a chronic or maintenance manner (e.g., methylphenidate for certain chronic conditions).
5. The Department will accept certain original shelf package sizes of medication, under the following conditions:
    a. An original shelf package of 480 ml, or less when not packaged in the pint size, is sufficient for the quantity limitations requirement for liquids. This also applies to unit dose systems;
    b. An original shelf package of l00 tablets or capsules, or less when not available in the 100 tablet or capsule size, for seldom-prescribed solid dosage drugs is sufficient for the quantity limitations requirement;
    c. Original shelf packages of l00 tablets or capsules of routinely prescribed drugs are not acceptable as sufficient for fulfillment of the quantity limitations requirement. The full month's supply shall be prescribed and dispensed; and
    d. Ready-made ointments, creams, etc., when used in a chronic or maintenance manner, may be dispensed in an original shelf package size provided the original size is closest to the needed amount of medication. This also applies to unit dose systems.

16-004.08 Utilization: Since it is the pharmacist's professional responsibility to ascertain that drugs are being utilized according to the prescriber's directions and that no abuse or overuse exists, the Department will not reimburse pharmacists for prescriptions which demonstrate a lack of this professional obligation. Providers are required to maintain patient record systems or other adequate records to prevent these errors in dispensing.

The Department's professional staff is responsible for determining whether a claim violates the Department's regulations.

The NE-POP system will identify drug claims when potential overuse exists; these claims will be denied.

16-004.09 Tobacco Cessation: Medicaid covers tobacco cessation services as practitioner and pharmacy services under the following conditions:

1. Up to two tobacco cessation sessions may be covered in a 12-month period. A session is defined as medical encounters and drug products as listed in items 2 and 3 below. Client access to the Nebraska Tobacco Free Quitline will be unlimited.
2. Practitioner Office Visits:
   a. Clients shall see their medical care provider (physician/mid-level practitioner) for evaluation particularly for any contraindications for drug products and to obtain prescription(s) if tobacco cessation products are needed.
   b. (1) In addition to the evaluation under item 2a, a total of four tobacco cessation counseling visits with a medical care provider or tobacco cessation counselor (see 471 NAC 16-002.04) are covered for each tobacco cessation session. This may be a combination of intermediate or intensive tobacco cessation counseling visits.
   (2) Tobacco cessation counseling provided by a Tobacco Cessation counselor shall be ordered by the physician/mid-level practitioner.
3. Tobacco cessation products are covered by Medicaid as a pharmacy service (see 471 NAC 16-000) for those clients 18 years of age or older who require that particular assistance.
   a. Coverage of products used for tobacco cessation is limited to a maximum 90 days supply in one tobacco cessation session. Up to two 90 day supplies may be covered in a 12 month period, beginning with the date the first prescription for the products is dispensed.
   b. Tobacco cessation products will only be covered when clients are currently enrolled with and actively participating in the Nebraska Tobacco Free Quitline. Disenrollment or lack of active participation in the Nebraska Tobacco Free Quitline will result in discontinuation of Medicaid coverage of tobacco cessation drug products.
4. Nebraska Tobacco Free Quitline: For coverage of tobacco cessation products, clients shall be enrolled in and active with the Nebraska Tobacco Free Quitline. Referral to the Quitline may be made by a medical professional (physician/mid-level practitioner) or a self referral.

16-005 Payment for Pharmacy Services

16-005.01 Professional Dispensing Fees

16-005.01A: A professional dispensing fee of $10.02 will be assigned to each claim payment based on the lesser of methodology described below.

16-005.01B Dispensing Physicians: The Department assigns a professional dispensing fee to a dispensing physician only when there is no pharmacy within a 25-mile radius of the physician's place of practice.

16-005.02 Reimbursement Methodology

Note: Payment levels for all drugs will not exceed, in the aggregate, upper levels of reimbursement established by federal law.

16-005.02A Brand Necessary Certification of Drugs: The Federal Upper Limit (FUL) or State Maximum Allowable Cost (SMAC) limitations will not apply in any case where the prescribing physician certifies that a specific brand is medically necessary. In these cases, the usual and customary charge or National Average Drug Acquisition Cost (NADAC) will be the maximum allowable cost. The prescriber must certify on Form MC-6 that a brand name is medically necessary.

16-005.02A1 Completion of Form MC-6: The Department requires completion of the prescriber certification form to meet federal requirements:

1. Form MC-6 will contain the handwritten signature of the prescriber. Rubber stamp signatures and initials are not acceptable;
2. A separate Form MC-6 is required for each drug product;
3. Form MC-6 will be submitted to the Department or the Department’s designated contractor;
4. Notice of approval or denial will be returned to the dispensing pharmacy via fax. Copies are to be retained by the dispensing pharmacy and serve as proof of certification;
5. The original and subsequent prescriptions will contain designation consistent with Nebraska pharmacy practice law noting drug product selection is not permitted; and
6. The prescriber will certify the effective period (From and To) dates on Form MC-6. The duration will not exceed one year. A new Form MC-6 is required when the effective dates of the certification expire.

16-005.03 Pricing Instructions: Pharmacists will not, under any circumstances, submit charges to the Department which exceed the pharmacy's usual and customary charge.

16-005.03A Pricing: Any loss leader prices, shelf prices, sale prices, cash only prices, coupon certificates, newspaper or brochure ad prices that are in effect on the date the prescription is dispensed will be considered the pharmacy's usual and customary charge to the general public.

16-005.03B Price Matching: When a pharmacy lowers its usual and customary price for a prescription (for example: to match a competitor's price), all claims submitted to Medicaid for the same drug and quantity dispensed during that business day will also be billed at the lowered price.

16-005.04 Payment Methodology

16-005.04A Legend, Non-legend Drugs and Compounded Prescriptions: The Nebraska Medicaid Drug Program is required to reimburse ingredient cost for covered outpatient legend and non-legend drugs at the lowest of:

a. The usual and customary charge to the public;
b. The National Average Drug Acquisition Cost (NADAC), plus the established professional dispensing fee;
c. The Affordable Care Act (ACA) Federal Upper Limit (FUL), plus the established professional dispensing fee; or
d. The calculated State Maximum Allowable Cost (SMAC), plus the established professional dispensing fee.

Backup Ingredient Cost Benchmark

If National Average Drug Acquisition Cost (NADAC) is not available, the allowed ingredient cost will be the lesser of Wholesale Acquisition Cost (WAC) + 0%, State Maximum Allowable Cost (SMAC) or the Affordable Care Act (ACA) Federal Upper Limit (FUL), plus the established professional dispensing fee.

Specialty Drugs

Specialty drugs will be reimbursed at National Average Drug Acquisition Cost (NADAC). If National Average Drug Acquisition Cost (NADAC) is not available, then the Backup Ingredient Cost Benchmark will apply.

340B Drug Pricing Program

Covered legend and non-legend drugs, including specialty drugs, purchased through the Federal Public Health Service's 340B Drug Pricing Program (340B) by covered entities that carve Medicaid into the 340B Drug Pricing Program, will be reimbursed at the 340B actual acquisition cost, but no more than the 340B ceiling price, plus the established professional dispensing fee. A 340B contract pharmacy under contract with a 340B covered entity described in section 1927 (a)(5)(B) of the Act is not covered.

Federal Supply Schedule (FSS)

Facilities purchasing drugs through the Federal Supply Schedule (FSS) will be reimbursed at no more than their actual acquisition cost, plus the established professional dispensing fee.

Clotting Factor

a. Pharmacies dispensing Antihemophilic Factor products will be reimbursed at the lesser of methodology, plus the established professional dispensing fee. If National Average Drug Acquisition Cost (NADAC) is not available, the lesser of methodology for the allowed ingredient cost will be the Wholesale Acquisition Cost (WAC) + 0%, the Average Sales Prices (ASP) + 6%, or the Affordable Care Act (ACA) Federal Upper Limit (FUL); and

b. Pharmacies dispensing Antihemophilic Factor products purchased through the Federal Public Health Service's 340B Drug Pricing Program (340B) by pharmacies that carve Medicaid into the 340B Drug Pricing Program will be reimbursed at the 340B actual acquisition cost, but no more than the 340B ceiling price, plus the established professional dispensing fee.

Drugs Purchased at Nominal Price

Facilities purchasing drugs at Nominal Price (outside of Federal Public Health Service's 340B Drug Pricing Program [340B] or Federal Supply Schedule [FSS]) will be reimbursed by their actual acquisition cost, plus the established professional dispensing fees.

Investigational Drugs

Excluded from coverage.

Tribal Rates

Tribal pharmacies will be paid the federal encounter rate.

Certified Long-Term Care

Pharmacies providing covered outpatient prescription services for Certified Long-Term Care beneficiaries will be reimbursed for ingredient cost using the lesser of methodology, plus the established professional dispensing fee.

16-005.04B Unit Dose Prescriptions: The Department defines unit dose at 471 NAC 16-004.05D. Unit dose providers are allowed one professional dispensing fee per recipient and drug per month. For exceptions to the one professional dispensing fee per recipient and drug per month, see 471 NAC 16-004.07E.

16-005.04C Sales Tax: The State of Nebraska is tax exempt; therefore, providers do not charge sales tax on claims to the Department.

16-005.05 Third Party Liability: The pharmacy provider will bill any third party resource for claims before billing Medicaid. All third party resources available to Medicaid clients shall be utilized for all or part of their medical costs before Medicaid. Third party resources are any individual, entity, or program that is, or may be, liable to pay all or part of the cost of any medical services furnished to a client. See 471 NAC 3-004.

16-005 Payment for Pharmacy Services

16-005.01 Dispensing Fees

16-005.01A Pharmacies: The Department assigns a dispensing fee to each individual retail pharmacy and hospital pharmacy. The fee is calculated from the information obtained through the Department's prescription survey. The Department notifies each pharmacy of its dispensing fee.

Note: If a pharmacy accepts a lesser fee from any other third party program, the Department may adjust its assigned dispensing fee to reflect this variance in total charge.

16-005.01B Dispensing Physicians: The Department assigns a dispensing fee to a dispensing physician only when there is no pharmacy within a 25-mile radius of the physician's place of practice.

16-005.02 Drug or Ingredient Cost

16-005.02A Federal Upper Limit (FUL): Certain multiple source drug products will have an upper limit of reimbursement assigned by the Federal Government. The Federal Upper Limit is established by the Centers for Medicare & Medicaid Services (CMS) in accordance with applicable federal laws and regulations.

16-005.02B State Maximum Allowable Cost (SMAC): Certain drug products will have a state maximum allowable cost assigned by the Division of Medicaid and Long-Term Care. The SMAC limit is the cost at which the drug is widely and consistently available to pharmacy providers in Nebraska. The determination of which products are assigned SMAC limits is the direct responsibility of the Division of Medicaid and Long-Term Care in conjunction with the Nebraska Pharmacists Association Medicaid Advisory Committee. Any individual or organization may request a revision in a SMAC limit directly from the Department.

The Department notifies all pharmacies of products which have been designated as SMAC products and the respective SMAC values via the NE-POP system and on the Department's website.

16-005.02C Estimated Acquisition Cost (EAC): All drug products, including the FUL products and SMAC products, will be assigned an estimated acquisition cost. The EAC is defined as the average wholesale price (AWP) as published by the drug reference file utilized by the NE-POP system less eleven percent, or Wholesale Acquisition Cost (WAC) as published by the drug reference file utilized by the NE-POP system plus 6.8 percent. The Department will be responsible for assigning the EAC limits for all drug products.

Note: Payment levels for all drugs will not exceed, in the aggregate, upper levels of reimbursement established by federal code or regulation.

16-005.02D Brand Necessary Certification of FUL/SMAC Drugs: The FUL/SMAC limitation does not apply when the prescribing physician certifies on Form MC-6 that a brand name product is medically necessary and the Department shall reimburse the pharmacy provider at the EAC value for the trade name drug product. If Form MC-6 is not completed, the Department shall reimburse the pharmacy at the FUL/SMAC limit for the drug product. In order to override the FUL/SMAC on an innovator multisource drug the prescriber shall certify the product is medically necessary for the well being of the patient.

16-005.02D1 Completion of Form MC-6: The Department requires completion of the prescriber certification form to meet federal requirements.

1. Form MC-6 shall contain the handwritten signature of the prescriber. Rubber stamp signatures, initials, etc., are not acceptable.
2. A separate Form MC-6 is required for each drug product.
3. Form MC-6 shall be submitted to the Department or the Department's designated contractor.
4. Notice of approval or denial will be returned to the dispensing pharmacy via fax. Copies are to be retained by the dispensing pharmacy and serve as their proof of certification.
5. The original and subsequent prescriptions shall contain designation consistent with Nebraska pharmacy practice statutes noting drug product selection is not permitted.
6. The prescriber shall certify the effective period (From and To) dates on Form MC-6. The duration shall not exceed one year. A new Form MC-6 is required when the effective dates of the certification expire.

16-005.03 Pricing Instructions: Pharmacists shall not, under any circumstances, submit charges to the Department which exceed the pharmacy's usual and customary charge.

16-005.03A Pricing: Any loss leader prices, shelf prices, sale prices, cash only prices, coupon certificates, newspaper or brochure ad prices, that are in effect on the date the prescription is dispensed shall be considered the pharmacy's usual and customary charge to the general public.

16-005.03B Price Matching: When a pharmacy lowers its usual and customary price for a prescription (for example: to match a competitor's price), all claims submitted to Medicaid for the same drug and quantity dispensed during that business day shall also be billed at the lowered price.

16-005.04 Payment Methodology

16-005.04A Legend Drugs and Compounded Prescriptions: The Department reimburses legend drugs and compounded prescriptions at the lower of -

1. Product cost (EAC or FUL or SMAC) plus the assigned dispensing fee(s); or
2. The pharmacy's usual and customary charge to the general public (see 471 NAC 16-005.03).

16-005.04B Unit Dose Prescriptions: The Department defines unit dose at 471 NAC 16-004.05D. Unit dose providers are allowed one dispensing fee per recipient and drug per month. For exceptions to the one dispensing fee per recipient and drug per month see 16-004.07E.

The Department reimburses unit dose prescriptions at the lowest of -

1. Product cost (EAC or FUL or SMAC) plus assigned dispensing fee(s); or
2. The pharmacy's usual and customary charge to the general public (see 471 NAC 16-005.03).
   Note: The Department does allow the pharmacy provider to maintain a different usual and customary charge for those drug products dispensed through a recognized unit dose distribution system than the same drug products dispensed through a bottle. This applies only to legend drugs dispensed through a unit dose distribution system (capsules, tablets, etc., and not creams, or liquids). This usual and customary variance is not allowable for OTC drug products.

16-005.04C OTC Drugs: The Department reimburses listed OTC drugs at the lowest of -

1. Product cost (EAC or FUL or SMAC) plus the appropriate dispensing fee(s); or
2. The pharmacy's usual and customary shelf price to the general public (maximum of FUL, SMAC, or EAC cost, plus a 50% mark-up).

16-005.04D Sales Tax: The State of Nebraska is tax exempt; therefore, providers do not charge sales tax on claims to the Department.

16-005.05 Third Party Liability: The pharmacy provider shall bill any third party resource for claims before billing Medicaid. All third party resources available to Medicaid clients shall be utilized for all or part of their medical costs before Medicaid. Third party resources are any individual, entity, or program that is, or may be liable to pay all or part of the cost of any medical services furnished to a client. See 471 NAC 3-004 for further policy on third party liability.

16-006 Billing Requirements

16-006.01 Drug Claims: Claims for pharmacy services shall meet the requirements listed in the NE-POP System user's manual. The same standards apply to non-NE-POP system claims.

16-006.02 Medical Supplies and Durable Medical Equipment Claims: Providers shall bill electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837) or Form CMS-1500, "Health Insurance Claim Form," (see 471-000-55) to submit claims for medical supplies and durable medical equipment unless otherwise stipulated. See 471 NAC 7-000 on durable medical equipment and medical supplies.

16-006.03 Electronic Media Claim (EMC) Requirements: While the Department utilizes the NE-POP System, providers are responsible for any errors, omissions, or inappropriate billings submitted by themselves or on their behalf by billing agents. The submission of any EMC for reimbursement by the provider or by an approved company or organization on behalf of an approved provider constitutes certification that -

1. The services or items for which payment is claimed were provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973;
2. The amounts claimed are in accordance with the Department's regulations, and no additional charge (other than Medicaid copayment) has been or will be claimed;
3. Each service is documented and the documentation is open to audit by the Department or its agents; and
4. The charge does not exceed the pharmacy's usual and customary charge to the general public.

CHAPTER 18-000 PHYSICIANS' SERVICES

18-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), physicians, including osteopaths, must be licensed at the time the service is provided by the Nebraska Department of Health and Human Services, Division of Public Health, or its equivalent in another state.

18-001.01 Provider Agreement: The physician or the physician's authorized agent must complete and sign Form MC-19, "Medical Assistance Provider Agreement" (see 471-000-90). The provider submits Form MC-19 to the Department for approval of the provider enrollment. Providers not meeting the conditions of the provider agreement are not eligible for participation in NMAP.

18-001.02 Independent Clinical Laboratories: In addition to the provider agreement, independent clinical laboratories must meet the following requirements:

1. When state or applicable local law requires licensing of independent clinical laboratories, the laboratory must be licensed under the law; and
2. The laboratory must meet the health or safety requirements of the Department of Health and Human Services (HHS).

For a Nebraska independent lab to be an approved provider under NMAP, the Division of Medicaid and Long-Term Care must receive a copy of Form CMS-1539, "Medicaid/Medicare Certification and Transmittal," (see 471-000-66) which displays current Medicare certification from the CMS Regional Office. The CMS Regional Office updates certification information and sends the information to the Division according to the federal time frame which is currently in effect for independent clinical laboratory surveys. For an out-of-state independent clinical lab to be an approved provider under NMAP, the Division must request verification of certification from the CMS Regional Office. The Division approves or denies enrollment based on the certification information received from the CMS Regional Office.

18-002 Covered Services: NMAP covers medically necessary physicians' services within program guidelines which are provided -

1. Within the scope of the practice of medicine or osteopathy as defined by Nebraska state law; and
2. By, or under the personal supervision of, an individual licensed under Nebraska law to practice medicine or osteopathy.

Physicians' services may be provided at the physician's office, the client's home, a hospital, a long term care facility, or elsewhere.

18-002.01 Facility Based Physician Clinics: Physician Clinic services provided in a hospital location or a facility under the hospital's licensure are considered content of the physician service, not outpatient hospital services. Physician clinic services are defined as the professional activity, any drugs and supplies used during that professional encounter and any other billable service provided in the physician clinic area.

1. Nebraska Medicaid does not recognize facility/hospital based non-emergency physician clinics for billing, reimbursement or cost reporting purposes except for itinerant physicians as defined in 471 NAC 18-004.41/10-005.21.
2. Services and supplies incident to a physician's professional service provided during a specific encounter are covered and reimbursed as physician clinic services if the service or supply is:
   a. Of the type commonly furnished in a physician's office;
   b. Furnished as an incidental, although integral, part of the physician professional service; and
   c. Furnished under the direct personal supervision of the physician.
3. The Physician's clinic services must be billed to the Medicaid Program on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

18-002.02 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 6 listed in the definition of "Treatment Services" in 471 NAC 33-001.03. These services must be prior authorized by the Division of Medicaid and Long-Term Care.

18-003 Non-Covered Services

18-003.01 Surgical Procedures: NMAP does not cover -

1. Acupuncture;
2. Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography or multi-plane, supervision and interpretation in conjunction with cineradiography;
3. Angiocardiography, utilizing CO_2 method, supervision and interpretation only;
4. Angiography, coronary, unilateral selective injection supervision and interpretation only, single view unless emergency;
5. Angiography, extremity, unilateral, supervision and interpretation only, single view unless emergency;
6. Ballistocardiogram;
7. Basal metabolic rate (BMR);
8. Bronchoscopy, with injection of contrast medium for bronchography or with injection of radioactive substance;
9. Circumcision, female;
10. Excision of carotid body tumor, with or without excision of carotid artery, when used as a treatment for asthma;
11. Extra-intra cranial arterial bypass for stroke;
12. Fabric wrapping of abdominal aneurysm;
13. Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain;
14. Fascia lata by stripper when used as a treatment for lower back pain;
15. Hypogastric or presacral neurectomy (independent procedure);
16. Hysterotomy, non-obstetrical, vaginal;
17. Icterus index;
18. Ileal bypass or any other intestinal surgery for the treatment of obesity; and
19. Kidney decapsulation, unilateral and bilateral;
20. Ligation of femoral vein, unilateral and bilateral, when used as treatment for post-phlebotic syndrome;
21. Ligation of internal mammary arteries, unilateral or bilateral;
22. Ligation of thyroid arteries (independent procedure);
23. Nephropexy: fixation or suspension of kidney (independent procedure), unilateral;
24. Omentopexy for establishing collateral circulation in portal obstruction;
25. Perirenal insufflation;
26. Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study;
27. Protein bound iodine (PBI);
28. Radical hemorrhoidectomy, whitehead type, including removal of entire pile bearing area;
29 Reversal of tubal ligation or vasectomy;
30. Sex change procedures;

31. Splanchicectomy, unilateral or bilateral, when used as a treatment for hypertension;
32. Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both;
33. Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as a treatment for hypertension;
34. Uterine suspension, with or without presacral sympathectomy.

18-003.02 Obsolete Tests: NMAP does not routinely cover the following diagnostic tests because they are obsolete and have been replaced by more advanced procedures:

1. Amylase, blood isoenzymes, electrophoretic;
2. Chromium, blood;
3. Guanase, blood;
4. Zinc sulphate turbidity, blood;
5. Skin test, cat scratch fever;
6. Skin test, lymphopathia venereum;
7. Circulation time, one test;
8. Cephalin flocculation;
9. Congo red, blood;
10. Hormones, adrenocorticotropin quantitative animal tests;
11. Hormones, adrenocorticotropin quantitative bioassay;
12. Thymol turbidity, blood;
13. Skin test, actinomycosis;
14. Skin test, brucellosis;
15. Skin test, leptospirosis;
16. Skin test, psittacosis;
17. Skin test, trichinosis;
18. Calcium, feces, 24-hour quantitative;
19. Starch; feces, screening;
20. Chymotrypsin, duodenal contents;
21. Gastric analysis pepsin;
22. Gastric analysis, tubeless;
23. Calcium saturation clotting time;
24. Capillary fragility test (Rumpel-Leede);
25. Colloidal gold;
26. Bendien's test for cancer and tuberculosis;
27. Bolen's test for cancer; and
28. Rehfuss test for gastric acidity.

These tests may be covered only if the physician who performs or orders the test justifies the medical necessity for it. The justification must be submitted with the claim when submitted to–NMAP. Staff in the Medicaid Division determine that satisfactory medical necessity exists from the physician's justification.

18-003.03 Services Required to Treat Complications or Conditions Resulting from Non-Covered Services: NMAP may consider payment for medically necessary services that are required to treat complications or conditions resulting from non-covered services.

Medical inpatient or outpatient hospital services are sometimes required to treat a condition that arises from services which NMAP does not cover, e.g., cosmetic surgery which is excluded from Medicaid coverage by statute. Payment may be made for services furnished under these circumstances if they are reasonable and necessary in all other respects. Examples of services that may be found to be covered under this policy are the repair of complications from transsexual surgery, repair of complications from cosmetic surgery, and removal of a non-covered bladder stimulator.

If the services in question are determined to be part of a previous non-covered service, i.e., an extension or a periodic segment of a non-covered service or followup care associated with it, the subsequent services will be denied. For example, when a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's prognosis, these visits are not covered.

18-003.04 Services Not Reasonable and Necessary: NMAP does not cover items and services which are not reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the function of a malformed body member.

18-003.05 Surgical Assistant Fees: NMAP does not cover surgical assistance fees for

1. Laparoscopy, including laparoscopic tubal ligation;
2. Tonsillectomy, adenoidectomy, myringotomy;
3. Conservative or closed fracture care; and
4. Uncomplicated procedures of the integument.

Additional assistant fees may be determined to be noncovered during the utilization review process.

18-003.06 Endometrial Aspiration: NMAP does not cover vacutage type or other endometrial aspiration or curettage unless the provider submits the pathologist's report on the tissue with all claims for this service. For diagnoses of absent, delayed, or late menstruation, the physician shall administer a pregnancy test to determine that the client is not pregnant. When requested, the provider shall submit copies of clients' medical records to NMAP. Reimbursement must be withheld or refunded if NMAP does not receive the requested documentation. A non-pregnant diagnosis must be indicated on Form CMS-1500, "Health Insurance Claim Form," (see 471-000-62) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) before NMAP can make payment for these procedures.

18-004 Limitations and Requirements for Certain Services

18-004.01 Prior Authorization: NMAP requires that physicians request prior authorization from the Medicaid Division before providing -

1. Medical transplants, as follows:
   a. Heart transplants;
   b. Kidney transplants;
   c. Bone marrow transplants (allogenic and autologous); and
   d. Liver transplants;
2. Abortions;
3. Cosmetic and reconstructive surgery;
4. Gastric bypass surgery for obesity which includes the following procedures:
   a. Gastric bypass;
   b. Gastric stapling; and
   c. Vertical banded gastroplasty;
5. Out-of-State services (Exception: Prior authorization is not required for emergency services);
6. Established procedures of questionable current usefulness;
7. Procedures which tend to be redundant when performed in combination with other procedures;
8. New procedures of unproven value;
9. Certain drug products, as specified in 471 NAC 18-004.25C and 18-004.25C1; and
10. All non-emergency outpatient Computerized tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans. See 471 NAC 18-004.30A.

18-004.01A Prior Authorization Procedures: The physician must request prior authorization for these services in writing or electronically using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instruction at 471-000-50) prior to providing the service.

18-004.01A1 Request for Additional Evaluations: NMAP shall request additional evaluations when the medical history for the request is questionable or when there is not sufficient information to support the requirements for authorization.

18-004.01A2 Prior Authorization Approval/Denial Process: The prior authorization request review and determination must be completed by one or all of the following Department representatives:

1. Medical Director;
2. Designated Department Program Specialists; and
3. Medical Consultants for the Department for certain specialties.

18-004.01A3 Notification Process: Upon determination of approval or denial, the Department shall send a written notification to the following as applicable to the request:

1. Physician(s) submitting or contributing to the request; and
2. Caseworker when appropriate.

18-004.01B Verbal Authorization Procedures: NMAP may issue a verbal authorization when circumstances are of an emergency nature or urgent to the extent that a delay would place the client at risk of receiving medical care. When a verbal authorization is granted, a written request or electronic request using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) must be submitted within 14 days of the verbal authorization. A written or electronic response from the Department will be issued upon completion of the review.

18-004.01C Billing and Payment Requirements: Claims submitted to NMAP for services defined as requiring prior authorization will not be paid without approval from the Department. A copy of the approval documentation issued by the Department is not needed for submission with the claim unless instructed to do so as part of the authorization notification.

18-004.02 Hospital Admission Diagnostic Procedures: The major factors which are considered to determine that a diagnostic procedure performed as part of the admitting procedure to a hospital is reasonable and medically necessary are -

1. The test is specifically ordered by the admitting physician, or a hospital staff physician responsible for the patient when there is no admitting physician (i.e., the test is not provided on the standing orders of a physician for all his/her patients);
2. The test is medically necessary for the diagnosis or treatment of the individual patient's condition; and
3. The test does not unnecessarily duplicate the same test performed on an outpatient basis before admission or performed in connection with a recent hospital admission.

18-004.03 Minor Surgical Procedures: Reimbursement for excision of lesions of the skin or subcutaneous tissues include all services and supplies necessary to provide the service. NMAP does not make additional reimbursement for suture removal to the physician who performed the initial services or to a hospital. If the sutures are removed by a non-hospital-based physician who is not the physician who provided the initial service, NMAP may approve separate payment for the suture removal.

18-004.04 Treatment for Obesity: NMAP will not make payment for services provided when the sole diagnosis is "obesity".

Obesity itself cannot be considered an illness. The immediate cause is a caloric intake which is persistently higher than caloric output. When obesity is the only diagnosis, treatment cannot be considered reasonable and necessary for the diagnosis or treatment of an illness or injury.

While obesity is not itself considered an illness, there are conditions which can be caused by or aggravated by obesity. This may include, but is not limited to the following: hypothyroidism, Cushing's disease, hypothalamic lesions, cardiac diseases, respiratory diseases, diabetes, hypertension, and diseases of the skeletal system. Treatment for obesity may be covered when the services are an integral and necessary part of a course of treatment for another serious medical condition.

18-004.04A Intestinal By-Pass Surgery: The safety of intestinal by-pass surgery for the treatment of obesity has not been demonstrated. Severe adverse reactions such as steatorrhea, electrolyte depletion, liver failure, arthralgia, hypoplasia of bone marrow, and avitaminosis have sometimes occurred as a result of this procedure. NMAP does not consider this procedure to be reasonable and necessary, and does not cover the procedure.

18-004.04B Gastric By-Pass Surgery for Obesity: Gastric by-pass surgery for patients with extreme obesity may be covered when the surgery is -

1. Medically appropriate for the individual; and
2. Performed to correct an illness which caused the obesity or was aggravated by the obesity.

Physicians shall request prior authorization for gastric by-pass surgery prior to providing the service.

18-004.05 Breast Reconstruction Following Mastectomy: Because breast reconstruction following mastectomy is considered a relatively safe and effective noncosmetic procedure, NMAP may cover this service following initial treatment.

18-004.06 Sterilizations

18-004.06A Age Requirement: The Nebraska Medical Assistance Program is prohibited from paying for sterilization of individuals -

1. Under the age of 21 on the date the client signs Form MMS-100; or
2. Legally incapable of consenting to sterilization.

18-004.06B Coverage Conditions: NMAP covers sterilizations only when -

1. The sterilization is performed because the client receiving the service made a voluntary request for services;
2. The client is advised at the outset and before the request or receipt of his/her consent to the sterilization that benefits provided by programs or projects will not be withdrawn or withheld because of a decision not to be sterilized; and
3. Clients whose primary language is other than English must be provided with the required elements for informed consent in their primary language.

18-004.06C Procedure for Obtaining Services: Non-therapeutic sterilizations are covered by NMAP only when -

1. Legally effective informed consent is obtained on Form MMS-100, "Consent Form" (see 471-000-109) from the client on whom the sterilization is to be performed. A properly completed and legible Form MMS-100 must submitted to the Department before payment of claims for sterilization can be considered; and
2. The sterilization is performed at least 30 days following the date informed consent was given. The consent is effective for 180 days from the date the client signs Form MMS-100. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since s/he signed the informed consent for the sterilization. For a premature delivery, the client must have signed the informed consent at least 72 hours before the surgery is performed and at least 30 days before the expected date of delivery; the expected delivery date must be entered on Form MMS-100.

18-004.06D Informed Consent: Informed consent means the voluntary, knowing assent of the client who is to be sterilized after s/he has been given the following information:

1. A clear explanation of the procedures to be followed;
2. A description of the attendant discomforts and risks;
3. A description of the benefits to be expected;
4. Counseling concerning appropriate alternative methods, and the effect and impact of the proposed sterilization including the fact that it must be considered an irreversible procedure;
5. An offer to answer any questions concerning the procedures; and
6. An instruction that the individual is free to withhold or withdraw his/her consent to the sterilization at any time before the sterilization without prejudicing his/her future care and without loss of other project or program benefits to which the client might otherwise be entitled.

This information is shown on Form MMS-100, which must be completed by the client.

18-004.06E Sterilization Consent Forms: Form MMS-100, "Sterilization Consent Form," (see 471-000-109) may be ordered by the physician directly from the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care, or from the client's local office. The surgeon must submit a properly completed and legible Form MMS-100 to the Department before payment can be considered for the sterilization.

18-004.07 Hysterectomies: Form MMS-101, "Informed Consent Form," (see 471-000-110) in which the client states that she was informed before the surgery was performed that this surgical procedure will result in permanent sterility must be properly signed and dated by the client. The completed Form MMS101 must be submitted to the Department of Health and Human Services, by the surgeon before claims for the hysterectomy can be considered for payment.

Exception: NMAP does not require informed consent if -

1. The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the individual was already sterile before the hysterectomy and states the cause of the sterility; or
2. The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible, and the physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which s/he determined prior acknowledgment was not possible. The physician must also include a description of the emergency.

A copy of the surgeon's certification regarding the above exceptions must be submitted to NMAP before consideration of payment for associated with the hysterectomy.

18-004.07A Non-Covered Hysterectomies: NMAP shall not cover a hysterectomy if -

1. It was performed solely to make the woman sterile; or
2. If there was more than one purpose for the procedure, it would not have been performed except to make the woman sterile.

18-004.08 (Reserved)

18-004.09 Infertility: NMAP limits coverage for infertility to diagnosis and treatment of medical conditions when infertility is a symptom of a suspected medical problem, for example, thyroid disease, brain tumor, or hormone dysfunction. Reimbursement/coverage is not available when the sole purpose of the service is achieving a pregnancy.

18-004.10 (Reserved)

18-004.11 Alcohol and Drug Detoxification: NMAP limits reimbursement for alcohol and drug detoxification to medically necessary treatment for detoxification, subject to the Department's utilization review.

Many hospitals provide detoxification services during the more acute stages of alcohol and drug dependency when the patient may be suffering from delirium, confusion, trauma, unconsciousness, and is no longer able to socially function. Since the high probability and occurrency of medical complications during alcohol and drug withdrawal can necessitate the constant availability of physicians and/or complex medical equipment found only in the hospital setting, inpatient hospital care during the period is considered reasonable and necessary and is therefore covered under the program.

This period includes an average detoxification period of two to three days with an occasional need for up to five days when the patient's condition dictates. A detoxification program for a particular patient may exceed five days and be covered if determined medically necessary by NMAP. NMAP does not cover services when the detoxification needs of an individual no longer require an inpatient hospital setting.

18-004.12 Osteogenic Stimulation: Electrical stimulation to augment bone repair (osteogenic stimulation) can be performed either invasively or noninvasively.

18-004.12A Invasive Osteogenic Stimulation: Invasive devices provide electrical stimulation directly at the fracture site either through percutaneously placed cathodes or by implantation of a coiled cathode wire into the fracture site. For percutaneously placed cathodes, the power supply is externally placed and the leads connected to the inserted cathodes. For the implanted cathode, the power pack is implanted into soft tissue near the fracture site and subcutaneously connected to the cathode, creating a self-contained system with no external components. NMAP covers use of the invasive device only for non-union of long bone fractures. NMAP considers non-union to exist only after six months or more have elapsed without the fracture healing.

18-004.12B Non-Invasive Osteogenic Stimulation: For non-invasive device, opposing pads wired to an external power supply are placed over the cast. An electromagnetic field is created between the pads at the fracture site. NMAP covers use of the non-invasive device only for -

1. Non-union of long bone fractures;
2. Failed fusion; and
3. Congenital pseudoarthroses.

18-004.13 Biofeedback Therapy: Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Biofeedback therapy differs from electromyography, which is a diagnostic procedure used to record and study the electrical properties of skeletal muscle. An electromyography device may be used to provide feedback with certain types of biofeedback, however.

Biofeedback therapy is covered under NMAP only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is not covered for treatment of ordinary muscle tension states, for psychosomatic conditions, or for psychiatric conditions.

18-004.14 Sleep Disorder Clinics: Sleep disorder clinics are facilities in which certain conditions are diagnosed through the study of sleep. These clinics are primarily for research. Nevertheless, sleep disorder clinics may provide some diagnostic or therapeutic services which NMAP covers. These clinics must be affiliated with a hospital. Coverage for diagnostic services would under some circumstances be covered under provisions of the law different from those for coverage of therapeutic services.

18-004.14A Diagnostic Services: All reasonable and necessary diagnostic tests given for the medical conditions listed in 471 NAC 18-004.14B are covered when the following criteria are met:

1. The clinic must be affiliated with a hospital;
2. Patients must be referred to the sleep disorder clinic by their attending physicians. The clinic shall maintain a record of the attending physician's orders; and
3. The need for diagnostic testing must be confirmed by medical evidence, e.g., physician examinations and laboratory tests.

Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered.

18-004.14B Medical Conditions for which Diagnostic Testing is Covered: Diagnostic testing can be covered only if the patient has the symptoms or complaints of one of the following conditions. Most patients who undergo the diagnostic testing are not considered inpatients, although they may come to the facility in the evening for testing and then leave after their tests are over. The overnight stay is considered an integral part of these tests.

1. Narcolepsy: This term refers to a syndrome that is characterized by abnormal sleep tendencies, e.g., excessive daytime sleepiness or disturbed nocturnal sleep. Related diagnostic testing is covered if the patient has inappropriate sleep episodes or attacks (e.g., while driving, in the middle of a meal, in the middle of a conversation), amnesiac episodes, or continuous disability drowsiness. The sleep disorder clinic shall submit documentation that this condition is severe enough to interfere with the patient's well-being and health before Medicaid benefits may be provided for diagnostic testing. A maximum of three "sleep naps" to confirm a diagnosis of narcolepsy may be covered.
2. Sleep Apnea: This is a potentially lethal condition where the patient stops breathing during sleep. Three types of sleep apnea have been described - central, obstructive, and mixed. The nature of the apnea episodes can be documented by appropriate diagnostic testing. A maximum of one night stay per patient may be allowed.

18-004.14C Therapeutic Services: Sleep disorder clinics may at times render therapeutic as well as diagnostic services. Although only the diagnostic services indicated above are covered under Medicaid, therapeutic services may be covered provided they are standard and accepted services and are reasonable and medically necessary for the patient. Sleep disorder clinics must provide therapeutic services in the hospital outpatient setting. Therapeutic services may be provided for -

1. Insomnia;
2. Nocturnal myoclonus (muscle jerks);

3. Sleep apnea (typically central type);
4. Drug dependency;
5. Shift work and schedule disturbances;
6. Restless leg syndrome;
7. Hypersomnia (excessive daytime sleepiness);
8. Somnambulism;
9. Night terrors or dream anxiety attacks;
10. Enuresis; and
11. Bruxism.

18-004.15 Portable X-Ray Services: NMAP covers diagnostic x-ray services provided by certified a portable x-ray supplier when provided in a place of residence used as the patient's home and in nonparticipating institutions. These services must be performed under the general supervision of a physician and certain conditions relating to health and safety (see 471 NAC 18-004.15B) must be met.

NMAP also covers diagnostic portable x-ray services when provided in participating SNF's, under circumstances in which they cannot be covered as a SNF service, i.e., the services are not provided by the participating institution either directly or under arrangements that allow the institution to bill for the services.

If portable x-ray services are provided in a participating hospital under arrangement, the hospital shall bill for the service.

18-004.15A Certified Providers: To be approved as a provider under NMAP, providers of portable x-ray services must be certified by the CMS Regional Office.

For a Nebraska portable x-ray provider, NMAP must receive a copy of Form CMS-1539, "Medicare/Medicaid Certification and Transmittal," which displays Medicare certification from the CMS Regional Office.

For an out-of-state portable x-ray provider, Medicaid Division staff shall request verification of certification from the CMS Regional Office. The Department approves or denies enrollment based on the certification information received from the CMS Regional Office.

The CMS Regional Office updates certification information and sends the information to the Department according to the federal time frame which is currently in effect for portable x-ray providers.

18-004.15B Applicability of Health and Safety Standards: The health and safety standards apply to all suppliers of portable x-ray services, except physicians who provide immediate personal supervision during the administration of diagnostic x-ray services. Payment is made only for services of approved suppliers who have been found to meet the standards.

When the services of a supplier of portable x-ray services no longer meet the conditions of coverage, physicians responsible for supervising the portable x-ray services and having an interest in the supplier's certification status must be notified. The notification action regarding suppliers of portable x-ray equipment is the same as required for decertification of independent laboratories, and the same procedures are followed.

18-004.15C Covered Portable X-Ray Services: NMAP covers the following portable x-ray services:

1. Skeletal films involving arms and legs, pelvis, vertebral column, and skull;
2. Chest films which do not involve the use of contrast media (except routine screening procedures and tests in connection with routine physical examinations); and
3. Abdominal films which do not involve the use of contrast media.

18-004.15D Non-Covered Portable X-Ray Services: NMAP does not cover the following portable x-ray services:

1. Procedures involving fluoroscopy;
2. Procedures involving the use of contrast media;
3. Procedures requiring the administration of a substance to the patient or injection of a substance into the patient and/or special manipulation of the patient;
4. Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require that medical judgment be exercised;
5. Procedures requiring special technical competency and/or special equipment or materials;
6. Routine screening procedures; and
7. Procedures which are not of a diagnostic nature.

18-004.15E Billing Requirements: Claims for portable x-ray services must contain -

1. The name of the physician who ordered the service; and
2. A diagnosis of medical necessity.

18-004.15F Electrocardiograms: The taking of an electrocardiogram tracing by an approved provider of portable x-ray services may be covered as an "other diagnostic test." The health and safety standards in 471 NAC 18-004.15B must be met.

18-004.16 Durable Medical Equipment and Supplies: NMAP does not generally enroll hospitals, hospital pharmacies, long term care facilities, rehabilitation services or centers, or physicians as providers of durable medical equipment and medical supplies.

18-004.17 Surgery: The surgical procedure, including 14 days post-operative care, is reimbursed under a HCPCS surgery procedure code. When multiple surgical procedures are done at one time, the Department reimburses the primary procedure according to the Nebraska Medicaid Practitioner Fee Schedule. Any secondary procedures that add significant time and complexity to patient care are reimbursed at one-half of the amount that would be paid if the procedure were the primary procedure. Incidental procedures through the same incision (for example, incidental appendectomy, lysis of adhesions, excision of a previous scar, puncture of an ovarian cyst) are not considered separate secondary procedures for reimbursement.

18-004.17A Assistant Surgeon: When an assistant surgeon is required, reimbursement is made according to the Nebraska Medicaid Practitioner Fee Schedule. The assistant uses the appropriate modifier with the basic procedure code when submitting a claim (for example, 47600-80 cholecystectomy assist). See 471 NAC 18-003.05 for non-covered surgical assistant fees.

18-004.17B New or Unusual Surgical Procedures: NMAP may cover new or unusual surgical procedures. In all cases, the Medical Director shall determine the necessity or usefulness of the procedure. The physician shall submit requests for NMAP prior authorization by using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) or by completing and submitting a written request for prior authorization. Physicians shall obtain prior authorization for these procedures prior to providing the service from -

Medical Director
Medicaid Division
Nebraska Department of Health and Human Services Finance and Support
301 Centennial Mall South, 5th Floor
P.O. Box 95026
Lincoln, NE 68509

If approved, the Department sends a notification of authorization to the provider. The provider(s) shall submit a copy of the notification of authorization only when instructed to do so in the text of the authorization.

18-004.17C Second Surgical Opinion: NMAP makes payment for clients who desire a second physician's opinion concerning proposed surgery. This second physician shall bill the Department with a HCPCS consultation procedure code indicating the level of the consultation and identifying the service as a second surgical opinion on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

18-004.17D Cosmetic and Reconstructive Prior Authorization Procedures: In addition to the prior authorization requirements under 471 NAC 18-004.01, the surgeon who will be performing the cosmetic or reconstructive (C/R) surgery shall submit a request to the Medical Director. This request must include the following:

1. An overview of the medical condition and medical history of any conditions caused or aggravated by the condition;
2. Photographs of the involved area(s) when appropriate to the request;
3. A description of the procedure being requested including any plan to perform the procedure when it requires a staged process; and
4. When appropriate, additional information regarding the medical history may be submitted by the client's primary care physician.

Prior authorization request for cosmetic and reconstructive surgery must be submitted using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transaction Instructions at 471-000-50) or in writing by mail or fax to the following address:

Medical Director
Nebraska Department of Health and Human Services Finance and Support
Medicaid Division
P.O. Box 95026
Lincoln, NE 68509-5026

Fax Telephone Number: (402) 471-9092

18-004.17E Services Performed in an Ambulatory Surgical Center: In addition to the federally-identified ASC services, NMAP covers the certain state-defined services provided in an ambulatory surgical center (ASC). Payment for "facility services" provided in connection with the state-defined procedures will not exceed payment for the corresponding group of Medicare-covered ASC procedures. See the state-defined ASC services in 471-000-409.

Federally-identified ASC services are defined in 471 NAC 26-004.

18-004.18 Anesthesiology: NMAP covers anesthesiology services. See 471 NAC 18-004.33D.

18-004.19 Hospital Calls: NMAP reimburses only one primary physician's call per day in the hospital and only one visit per week by a physician consultant unless -

1. Unless the primary physician specifically states on Form CMS-1500 or electronically that more than one call was necessary because of serious illness or change in condition; and
2. Approval is given by the Medical Director.

18-004.19A Surveillance and Utilization Review (SUR) Criteria: The Department may contract with a medical review organization to review inpatient hospital services. The physician shall comply with all medical review requirements. For hospitalizations not subject to medical review, the Department's in-house utilization review will prevail. If a hospitalization is denied or reduced based on utilization review, the physician's claim may also be denied or reduced accordingly.

18-004.20 Approval of Payment for Emergency Room Services: At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

1. The patient is evaluated or treated for a medical emergency, accident, or injury (a medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances that may present a substantial risk to an individual's health unless immediate medical assessment and/or treatment is done);
2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as ancillary charges and included in the inpatient per diem); or
3. The patient is referred by a physician such as for allergy shots or when traveling (a written referral by the physician must be submitted with the claim);

The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency and bill accordingly. When the facility or the Department determines service are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of the applicable ratio of cost-to-charges. When these conditions are met, the physician's fee will be disallowed to the rate of a comparable office service. All other Medicaid allowable charges incurred in this type of visit will be paid according to 471 NAC 10-010.06 ff. for hospitals or according to the Nebraska Medicaid Practitioner Fee Schedule for physicians.

18-004.21 Prenatal, Delivery, and Postpartum Care: Medicaid covers physicians' services related to pregnancy. Routine prenatal care, delivery, six weeks' postpartum care, and routine urinalysis are reimbursed as a "package" service. The physician may claim, as independent procedures, those lab and medical services which are not related to the pregnancy or which are not included as part of the "package" service (i.e., urinalysis for urinary tract infections, treatment of fractures, etc.).

When billing Medicaid for prenatal, delivery, and postpartum care, the provider shall submit a claim at the time of delivery. One charge is submitted covering all -

1. Routine prenatal care, vaginal delivery, and postpartum care; or
2. Routine prenatal care, cesarean delivery, and postpartum care.

When the primary physician does not participate in the total obstetrical care, the partial care (prenatal, delivery, or postpartum care only) may be billed separately from the delivery using the appropriate procedure codes. An explanation for the partial care must be submitted with the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) (i.e., patient moved, delivered elsewhere, aborted, etc.). Providers shall use one procedure code, i.e., for prenatal care only, but shall provide individual dates of service on the claim.

18-004.22 Antigens: Medicaid may make payment for a reasonable supply of antigens that have been prepared for a particular patient even though the antigens have not been administered to the patient by the same physician who prepared them if -

1. The antigens are prepared by a physician who is a doctor of medicine or osteopathy; and
2. The physician who prepared the antigens has examined the patient and determined a plan of treatment and a dosage regimen.

The Department considers a reasonable supply of antigens to be not more than a 12-week supply of antigens that has been prepared for a particular patient at any one time. The reasonable supply limitation ensures that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient.

18-004.23 (Reserved)

18-004.24 Dialysis: NMAP follows Medicare's guidelines for coverage of dialysis.

18-004.25 Drugs

18-004.25A Covered Drugs: NMAP covers outpatient prescription drugs in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (Public Law 101-508) including:

1. Legend drugs;
2. Compounded prescriptions; and
3. Over-the-counter (OTC) drugs indicated as covered on the Nebraska Point of Purchase (NE-POP) System or listed on the Department's website.

See 471 NAC 18-004.25B, Non-Covered Services; 471 NAC 18-004.25C1, Products Requiring Prior Approval; coverage as indicated on NE-POP System; and the Department's website for exceptions to the above.

18-004.25A1 Preferred Drug List (PDL): The Medicaid Prescription Drug Act of 2008 requires the Department to establish and maintain a Preferred Drug List for the Medicaid program with the aid of the Pharmaceutical and Therapeutics Committee. Drugs designated as Preferred Drugs may be prescribed for Medicaid clients without prior authorization from the Department; however, some Preferred Drugs may have clinical claim limits to ensure appropriate use.

The Department will include on the Preferred Drug List prescribed drugs that are found to be therapeutically equivalent to or superior to other drug(s) within a therapeutic class, and the net cost of the drugs are equal to or less than other drugs within a therapeutic class after consideration of applicable rebates or discounts negotiated by the Department or it’s designated contractor.

Medications designated as Non-Preferred on the Preferred Drug List will be subject to prior authorization. The Pharmaceutical and Therapeutics Committee will develop criteria for use of medications with non-preferred status.

The Department will maintain an updated Preferred Drug List in electronic format and will make the list available to the public on the Department’s internet web site.

18-004.25A2 Compounded Prescriptions: A compounded prescription is a mixture of ingredients which the provider prepares in the pharmacy.

Any mixture of drugs which results in a commercially available OTC preparation is not considered a compounded prescription, for example, dilute HCL, MOM with cascara, OTC hydrocortisone preparations.

18-004.25A3 Over-the-Counter (OTC) Drugs: NMAP covers only OTC drugs indicated as covered on the NE-POP System or listed on the Department's website. OTC drugs must be prescribed by a licensed practitioner.

18-004.25B Non-Covered Services: Payment by NMAP will not be approved for:

1. More than a three-month supply of birth control tablets. More than a three-month supply of oral medication. More than 100 tablets or capsules of medication taken once daily. More than a three-month supply of any medication, except injectable medications. More than a one-month supply of any injectable medication, except insulin and those injectable drugs with a duration of greater than one month from one dose (e.g., Lupron Depot 4 month, Depo-Provera Contraceptive 150mg.).
2. Experimental drugs or non-FDA approved drugs;
3. Drugs or items when the prescribed use is not for a medically accepted indication;
4. Drugs or items prescribed or recommended for weight control and/or appetite suppression;
5. Liquors (any alcoholic beverage);
6. D.E.S.I. drugs (Drug Efficacy Study Implementation Program) and all identical, related, or similar drugs;
7. Personal care items (examples: non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, and contact solutions);
8. Medical supplies and certain drugs for nursing facility and intermediate care facility for the mentally retarded (ICF/MR) patients (see 471 NAC 7-000 and 16-004.07);
9. Over-the-counter (OTC) drugs not listed on the Department's web site;
10. Drugs or items used for cosmetic purposes or hair growth;
11. Baby foods or metabolic agents (Lofenalac, etc.,) normally supplied by the Nebraska Department of Health and Human Services (see 471 NAC 16-002.03 for exceptions);
12. Drugs distributed or manufactured by certain drug manufacturers or labelers that have not agreed to participate in the drug rebate program;
13. Products used to promote fertility;
14. Medications dispensed as partial month fills for nursing facility or group home residents when dispensed by more than one pharmacy;
15. Drugs, items or products of manufacturers/labelers that are identifiable as non-covered on the Ne-POP system or on the Department’s website;
16. Drugs, classes of drugs or therapeutic categories of drugs that are Medicare Part D Drugs and Medicare Part D Covered supplies or equipment, for all persons eligible for benefits under Medicare Part D, whether or not such persons are enrolled into a Medicare Part D Plan (see 471 NAC 3-004 for definitions of Medicare Part D Drugs, Medicare Part D Covered supplies and equipment, Medicare Part D and Medicare Part D plan); and

17. Drugs or classes of drugs approved by the Federal Food and Drug Administration for treatment of sexual or erectile dysfunction, or drugs or classes of drugs that are being used for the treatment of sexual or erectile dysfunction. Drugs or classes of drugs that are approved by the Federal Food and Drug Administration for treatment of sexual or erectile dysfunction and for conditions other than treatment of sexual or erectile dysfunction, and are prescribed for those other conditions may be covered, but NMAP may require prior authorization. (See 471 NAC 16-004).

18-004.25C Prior Authorization: The Department requires that authorization be granted prior to payment for certain drugs or items. Prior authorization may pertain to either certain drugs prescribed or certain physician administered drugs.

18-004.25C1 Prior Authorization of Prescription Drugs: Physicians wishing to prescribe these drugs must obtain prior authorization by submitting the request either by standard electronic transaction or by phone, fax or mail from either:

1. The Department's NE-POP contractor; or
2. The Pharmacy Consultant (or designee)
   Nebraska Department of Health and Human Services
   Division of Medicaid and Long-Term Care
   P. O. Box 95026
   301 Centennial Mall South, 5th Floor
   Lincoln, NE 68509
   Phone: (877) 255-3092
   FAX: (402) 471-9092
   E-Fax: (402)742-2348

The NE-POP contractor or the Department will respond to any request for prior authorization within 24 hours of receipt of the request.

18-004.25C2 Products Requiring Prior Approval: The following prescribed products require prior approval:

1. Sunscreens (Example: Presun 29, Solbar-50);
2. Certain modified versions, double-strength entities, or products considered by the Department to be equivalent to drug products contained on the state or federal upper limit listings (Example: Libritabs, Keftabs);
3. Human Growth Hormone;
4. Erythropoietin (Example: Epogen, Procrit);
5. Drugs or supplies intended for convenience use (Example: Refresh Ophthalmic 0.3 ml. and Novalin penfil insulin);
6. Drugs used for prevention of infection with respiratory syncytial virus (e.g., respiratory syncytial virus immune globulin, palivizumab); and

7. Certain drugs or classes of drugs used for gastrointestinal disorders, including but not limited to hyperacidity, gastroesophogeal reflux disease, ulcers or dyspepsia (examples: omeprazole, famotidine);
8. Certain drugs or classes of drugs used for relief of pain, discomfort associated with musculoskeletal conditions, inflammation or fever (examples: butorphanol, carisoprodol, tramadol);
9. Certain drugs or classes of drugs used for relief of cough and/or symptoms of the common cold, influenza or allergic conditions (examples: loratadine, zanimivir, oseltamivir);
10. Certain drugs or classes of drugs that are used for non-covered services or indications (see 471 NAC 18-004-25B Non-Covered Services) and for covered services or indications (examples: orlistat, sildenafil);
11. Certain drugs or classes of drugs on the state maximum allowable cost or federal upper limit listings;
12. Certain drugs or classes of drugs upon initial availability or marketing or when Nebraska Medicaid coverage begins; and
13. Certain drugs or classes of drugs that are used for tobacco cessation; and
14. Certain drugs or classes of drugs that are determined by the Pharmaceutical and Therapeutics Committee to not be placed onto the Preferred Drug List.

Identifiable products requiring approval prior to payment are designated as such on the NE-POP System or on the Department's website.

18-004.25C3 Prior Authorization of Physician Administered Drugs: Certain drugs administered in the clinical setting also require prior authorization.

Requests for authorization of these products for the Medicaid client in a Medicaid managed care plan must be done by the Managed Care Plan. The provider must contact the client's managed care plan for their prior authorization guidelines.

Prior authorization of these products for the fee for service Medicaid client must be requested from the Department by submitting the request either by standard electronic transaction, mail, or fax to:

Medicaid Medical Director (or designee)
Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
P.O. Box 95026
301 Centennial Mall South, 5th Floor
Lincoln, NE 6850
Fax: (402) 471-9092

18-004.25C4 Physician administered drugs requiring prior authorization include but are not limited to:

1. Any drug used for the prevention of respiratory synctial virus infections;
2. Certain drugs used for the treatment of multiple sclerosis;
3. Enzyme replacement therapy (ERT) for Lysosmal Storage Disorders;
4. IgE blocker therapies for asthma;
5. Certain drugs or classes of drugs upon initial availability or marketing or when Nebraska Medicaid coverage begins;
6. Services not covered under the Nebraska Medical Assistance Program (NMAP) the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. (See 471 NAC 33-001.04)

Provider bulletins found on the Medicaid website at www.hhss.ne.gov/med/pb/ will give further direction for prior authorization of specific drugs or classes of drugs.

18-004.25D ~~Physician Certification of FUL/SMAC Drugs~~ Brand Necessary Certification of Drugs : ~~If the prescribing physician requires that a brand name product of a federal upper limit (FUL) or a state maximum allowable cost (SMAC) designated drug is medically necessary, the Department requires the physician to sign and date Form MC-6, "Physician Certification," (see 471-000-84).~~ The Federal Upper Limit (FUL) or State Maximum Allowable Cost (SMAC) limitations will not apply in any case where the prescribing physician certifies that a specific brand is medically necessary. In these cases, the usual and customary charge or National Average Drug Acquisition Cost (NADAC) will be the maximum allowable cost. The prescriber must certify on Form MC-6 that a brand name is medically necessary.

18-004.25D1 Completion of Form MC-6: The Department requires completion of the physician certification form to meet federal requirements. Form MC-6 must:

1. Contain the handwritten signature of the prescribing physician. Rubber stamp signatures, initials, etc., are not acceptable.
2. A separate MC-6 Form is required for each drug product.
3. The original (top) copy of Form MC-6 must be submitted to the Department-designated contractor.
4. The duplicate copies are to be retained by the dispensing pharmacy provider and prescribing physician and serve as their proof of certification. The Department does not provide additional authorization.
5. The original and subsequent drug claims must be checked "dispense as written"; and
6. A new Form MC-6 is required when the effective dates of the certification expire or prescribing physician has changed.

18-004.25E Injections: The Department applies the following limitations to injectable (e.g. subcutaneous, intramuscular, intravenous) drug products:

1. Only those injections that are either self administered by the client or are administered for the client at the client's place of residence are reimbursable as prescribed (pharmacy) services. Home health services (see 471 NAC 9-000) must meet medical necessity criteria and are not authorized for client or provider convenience.
2. Injections that are administered by the physician in the clinical setting are not reimbursable through the outpatient drug program. Medications used in this manner are considered medical services and are to be purchased, used, and billed to the Department by the physician/clinic.

18-004.26 Family Planning Services: 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: Practitioner administered injectable medications will be reimbursed at Average Sales Prices (ASP) + 6% (Medicare Drug Fee Schedule); injectable medications not available on the Medicare Drug Fee Schedule will be reimbursed at Whole Acquisition Cost (WAC) + 6.8%, or manual pricing based on the provider's actual acquisition cost. Practitioner administered injectable medications, including specialty drugs, purchased through the Federal Public Health Service's 340B Drug Pricing Program (340B) will be reimbursed at the 340B actual acquisition cost and no more than the 340B ceiling price.
~~The Department will reimburse practitioner-administered injectable medications at 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 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 Health Care Common Procedure Coding System (HCPCS) procedure code for the medication, the correct number of units per the Health Care Common Procedure Coding System (HCPCS) description, the National~~/~~ Drug Code (NDC) of the drug administered, the National Drug Code (NDC) 'unit of measure' and the number National Drug Code (NDC) units. A Current Procedural Terminology (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 Health Care Common Procedure Coding System (HCPCS) code with the name and National Drug Code (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.

18-004.28A Allergy Injections: When the cost of the medication is not available (not listed in either The Drug Topics Red Book or The Blue Book), allergy injections are paid at the provider's submitted charge up to the maximum allowable dollar amount under the Nebraska Medicaid Practitioner Fee Schedule per injection which includes medication and injection fee. If the allergy medication is not prepared in the office of the physician administering the allergen and the administering physician incurs no expense for the supply (the supplier bills the Department separately), the Department reimburses the administering physician according to the NMAP Practitioner Fee Schedule for the injection fee. If the administering physician purchases the supply for administration in his/her office, the administering physician must not bill the Department for more than the cost of the supply. The Department must not exceed the maximum allowable dollar amount under the Nebraska Medicaid Practitioner Fee Schedule in reimbursement per allergy injection, which includes the cost of the medication and the injection fee.

18-004.28B Vitamin B-12 Injections: The Nebraska Medical Assistance Program does not cover injections which, by accepted standards of medical practice, are not considered specific or effective treatment for the particular condition for which they are given. Professional medical advice indicates that Vitamin B-12 injections are specific therapy for -

1. Gastrectomy;
2. Idiopathic steatorrhea;
3. Ileostomy;
4. Internal cancers;
5. Macrocytic anemia;
6. Megaloblastic anemia;
7. During or after radiation therapy;
8. Certain neuropathies, including posterolateral sclerosis, neuropathies associated with pernicious anemia, the acute exacerbation of a neuropathy due to malnutrition or alcoholism diabetic neuropathy;
9. Pernicious anemia, including primary anemia, Addisons, essential, idiopathic, malabsorption, Biermer's cyogenic, and malignant; and
10. Post-surgical and mechanical disorders, such as gastrectomy or re-section of small intestines.

NMAP covers Vitamin B-12 injections only when the claim shows one of these diagnoses.

18-004.28C Influenza Injections in Long Term Care Facilities: Because the services of a nurse to give injections are included in the compensation for long term care facilities, no payment is made to a physician giving influenza injections in these facilities.

18-004.28D Injectable Estrogens: NMAP does not pay for injectable estrogens for depression or osteoporosis associated with menopause.

18-004.28E Liver and Vitamin Injections: The Department does not pay for liver and vitamin injections.

18-004.28F Chemotherapy: Providers must bill for chemotherapy on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49), using HCPCS procedure codes for chemotherapy administration. One line is used for administration; a separate line is used for the drug. The drug used must be identified and claimed separately on the claim using the appropriate HCPCS procedure code, the number of units per the HCPCS description, the NDC of the drug administered, the NDC 'unit of measure', and the number of NDC units. For drugs that do not have a specific HCPCs code, the provider must use a miscellaneous chemotherapy code. The provider must indicate on or in the claim the name of medication, the dosage administered, the NDC number, NDC 'unit of measure', and the number of NDC units.

18-004.28G Immunizations: Routine immunizations are available to Medicaid covered children and adolescents from birth through age 20 under the EPSDT program. Vaccines for those clients age 18 and younger are available through the Vaccine for Children (VFC) program; NMAP will not reimburse for a physician's private stock vaccine when the vaccine is available through the VFC program.

When using VFC vaccines, only the administration is to be billed to the Department. This is done by adding the appropriate modifier to the vaccine code; see claim submission instructions for more detailed information. The billed charge for the administration must not exceed the VFC federally determined state maximum for Nebraska. Contact the Nebraska VFC program with any questions regarding the state maximum.

Medicaid reimbursement is available for the provider's private stock vaccine and the administration fee for immunizations of adolescents age 19 and 20.

Immunizations for adults (age 21 and older) are covered by Medicaid on a case by case basis for medical necessity.

It is not necessary to submit an NDC when billing for vaccines.

18-004.29 Laboratory Services: Laboratory services are microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, or pathological examinations or procedures performed on materials derived from the patient to provide information for the diagnosis or treatment of a disease or an assessment of the medical condition of the patient. These services may be provided in -

1. A physician's or group of physicians' private office;
2. A licensed/certified independent clinical laboratory; and
3. A hospital whose certification covers services performed in the laboratory.

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 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 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.

NMAP may cover laboratory tests that have been referred by one independent lab to another.

The Department does not reimburse a lab for handling services for tests referred to a second lab.

When a physician's private office sends the specimen to an independent clinical lab for processing, the Department pays for the procedure directly to the independent clinical lab. The Department does not reimburse the lab for collecting, handling, or drawing the specimen, sent in by a physician's office. The Department pays for specimens collected by venipuncture or catheterization obtained by the hospital or independent lab for hospital or independent lab patients. The Department does not reimburse the private physician for processing or interpreting tests performed outside his/her office. The Department does not allow reimbursement for collection of specimens in a nursing home or long term care facility.

If a physician performs some tests on a specimen and then sends the same specimen to an outside facility for additional procedures, the private physician may be reimbursed for the medically necessary procedures performed in his/her office plus a fee for drawing the specimen by venipuncture or obtaining urine by catheterization sent to a hospital or independent lab. The physician must indicate on or with the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) that the fee for obtaining the specimen by venipuncture or catheterization is for tests performed outside his/her office and submit the name of the facility performing the tests on the claim.

A specimen collection fee is not allowed for samples where the cost of collecting the specimen is minimal, such as a throat culture, a routine capillary puncture, or a pap smear.

18-004.30 Radiology Services: Radiology services are medically necessary services in which x-rays or rays from radioactive substances are used for diagnostic or therapeutic services and associated medical services necessary for the diagnosis and treatment of a patient. These services may be provided in -

1. A physician's or group of physicians' private office; or
2. A hospital whose certification covers the radiological services provided.

Claims for radiology procedures must have at least a provisional diagnosis or statement of symptoms. NMAP will not accept claims with a diagnosis of "routine radiology."

18-004.30A Prior Authorization of Radiology Procedures: Effective September 1, 2009, all non-emergency outpatient Computerized Tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans will require prior authorization. These prior authorization requirements apply for all Medicaid clients enrolled in fee-for-service programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital’s emergency room.

18-004.30B Physician's Private Office: When both the technical and professional components of medically necessary radiological procedures are performed in a physician's private office, NMAP may reimburse the physician's private office for the total procedure.

18-004.30C Hospital Radiology Services: When a physician orders medically necessary radiological services performed in a hospital, NMAP makes payment directly to the hospital and/or radiologist according to the terms of the financial arrangements between the hospital and the radiologist. NMAP does not reimburse the private physician(s) for interpreting radiology procedures performed outside his/her office.

18-004.30 Mammograms: NMAP covers mammograms when provided based on a medically necessary diagnosis. In the absence of a diagnosis, NMAP covers mammograms provided according to the American Cancer Society's periodicity schedule.

18-004.31 Ultrasound Diagnostic Procedures: NMAP covers ultrasound diagnostic procedures listed by Medicare under Category I. NMAP may review claims for these procedures to ensure that the techniques are medically appropriate and the general indications of Medicare's categories are met.

Because of rapid changes in the field of ultrasound diagnosis with respect to new diagnostic uses and medical appraisal of the safety and effectiveness of existing techniques, claims for uses other than those listed under Medicare's Category I will be reviewed before payment.

NMAP does not cover ultrasound procedures listed by Medicare under Category II.

18-004.32 Computerized Tomography (CT) Scans: NMAP covers diagnostic examinations of the head (head scans) and of certain other parts of the body (body scans) performed by computerized tomography (CT) scanners when -

1. Medical and scientific literature and opinion support the use of a scan for the condition;
2. The scan is reasonable and necessary for the individual patient; and
3. The scan is performed on a model of CT equipment that meets Medicare's criteria for coverage.

To be determined reasonable and necessary for the individual patient as required in item 2, the use of the CT scan must be medically appropriate considering the patient's symptoms and preliminary diagnosis. The Department may determine that the use of a CT scan as the initial diagnostic test was not reasonable and necessary because it was not supported by the patient's symptoms and complaints stated on the claim form or electronic format. The Department reviews claims for CT scans for evidence of abuse, such as the absence of reasonable indications for the scans, an excessive number of scans, or unnecessarily expensive types of scans.

18-004.33 Professional and Technical Components for Hospital Inpatient and Outpatient Diagnostic and Therapeutic Services: Hospital diagnostic and therapeutic services are procedures performed to determine the nature and severity of an illness or injury, or procedures used to treat disease or disorders. Hospital diagnostic and therapeutic services include both inpatient and outpatient hospital services.

Hospital diagnostic and therapeutic services are comprised of two distinct elements: the professional component and the technical component. Hospital services which have professional and technical components include but may not be limited to -

1. Pathology:
    a. Anatomical;
    b. Clinical;
2. Radiology;
3. Specialized diagnostic and therapeutic services:
    a. CT scans;
    b. Nuclear medicine;
    c. Dialysis treatments;
    d. Radiation therapy;
    e. Ultrasound;
4. Anesthesia;
5. Psychiatric services; and
6. Miscellaneous:
    a. Pulmonary function tests;
    b. EEG's; and
    c. EKG's.

NMAP may designate other services as having professional and technical components when the services are identified.

18-004.33A Professional Component: The professional component of hospital diagnostic and therapeutic services includes those physician's services directly related to the medical care of the individual patient (i.e., interpretation of laboratory tests, x-rays, EKG's, EEG's, etc.). A physician includes not only a specialist but also a physician who normally performs or supervises these services for all inpatients and outpatients of a hospital, even though the physician does not otherwise specialize in this field (i.e., laboratory, radiology, cardiopulmonary).

The professional component must be claimed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) (except for facilities paid under an all-inclusive rate) using the appropriate HCPCS code and where appropriate, modifier for professional component.

18-004.33A1 Coverage Conditions: To be covered as a professional component, the physician's services must -

1. Be personally provided to an individual patient by a physician;
2. Contribute directly to the diagnosis or treatment of an individual patient;
3. Ordinarily require performance by a physician;
4. Be medically necessary; and
5. For anesthesiology, laboratory, or radiology services, meet the requirements of 471 NAC 18-004.33D, 18-004.33E, and 18-004.33F.

18-004.33A2 Payment: The Department pays for the professional component of a physician's hospital diagnostic or therapeutic service as described in 471 NAC 18-006 ff. Payment for the professional component of a radiology service provided in a hospital is made according to the Nebraska Medicaid Practitioner Fee Schedule.

In the absence of available payment data as described in 471 NAC 18-006 ff., the Department pays for the professional component at a percentage of the Department's allowable fee for the total procedure. The percentage is established by the Department.

18-004.33B Technical Component: The technical component of hospital diagnostic and therapeutic services is comprised of two distinct elements:

1. Physicians' professional services not directly related to the medical care of the individual patient (i.e., teaching, supervision, administration, and other services that benefit the hospital's patients as a group); and
2. Hospital services (i.e., equipment, supplies, technicians, etc.).

The technical component for hospital inpatients and outpatients must be claimed by the hospital.

The Department's payment for the technical component includes payment for all non-physician services required to provide the procedure, such as stat fee, specimen handling, call back, room charges, etc.

18-004.33B1 Non-Physician Services and Items: The elimination of combined billing requires the separation of physician services (professional component) from non-physician services (technical component) for billing purposes.

All non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics, prosthetics, etc.) provided to hospital inpatients or outpatients must be billed by the hospital and must be provided directly by the hospital or under arrangements. If the services or items are provided under arrangements, the hospital is responsible for payment to the non-physician provider or supplier. The Nebraska Medical Assistance Program prohibits the "unbundling" of costs by hospitals for non-physician services or supplies provided to hospital patients, including ancillary services provided by another hospital.

All other non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics and prosthetics, etc.) provided to non-patients for primary use in other than the hospital setting must be billed by the provider/supplier of the service or item on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Exception: Take-home supplies and rental of apnea monitors.

Payment for the technical component for a medically necessary service required and/or ordered by a physician must be claimed by the hospital as a hospital service on the hospital claim form or electronic format.

18-004.33B1a Inpatient Services: All non-physician services, drugs, and items provided to hospital inpatients must be billed by the hospital. The hospital per diem includes payment for ancillary services, including outpatient services provided by another hospital to an inpatient (see 471 NAC 10-010.03 ff.). The hospital is responsible for payment to the non-physician provider or supplier.

18-004.33B1b Outpatient Services: All non-physician services, drugs, and items provided to hospital outpatients must be billed by the hospital. Payment for these services is made according to 471 NAC 10-010.06 ff. The hospital is responsible for payment to the non-physician provider or supplier.

All non-physician services, drugs, medical supplies, and items (durable medical equipment, orthotics and prosthetics, etc.) provided for primary use in the emergency room or outpatient facility must be billed by the hospital as outpatient services on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

All non-physician services, drugs, medical supplies, and items provided to non-patients for primary use in other than the outpatient facility or emergency room must be billed by the non-physician provider or supplier on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Exception: Apnea monitors.

The sale or rental of durable medical equipment for primary use in the patient's home or nursing home must be billed by the supplier on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Exception: Apnea monitors.

18-004.33B1c Inpatient Fittings: Fittings for durable medical equipment, orthotics and prosthetics, etc., provided to a hospital inpatient when the item itself is provided while the client is an inpatient must be billed by the hospital as an ancillary service. The hospital is responsible for payment to the supplier.

Fittings for durable medical equipment, orthotics and prosthetics, etc., provided to a hospital inpatient when the item itself is provided after the client is dismissed from the hospital must be billed by the supplier directly to the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

18-004.33C Billing for the Professional and Technical Components of Hospital Inpatient and Outpatient Diagnostic and Therapeutic Services: The professional component of hospital diagnostic and therapeutic services must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49), except for facilities paid under an all-inclusive rate. The technical component of hospital diagnostic and therapeutic services must be billed by the hospital.

A hospital may act as the billing agent for the physician's professional component.

Because Medicare assigns a separate provider number to each specialty for the hospital professional component, the Department requires a separate Medicaid provider number for each specialty for the hospital professional component. A separate provider agreement is required for each separate provider number. The professional component must be billed on the claim, using the appropriate provider number for the professional component of the appropriate specialty.

Only one specialty (one provider number) may be billed on each claim.

18-004.33C1 Pre-Admission Testing: NMAP does not cover pre-admission testing performed in a physician's office which is performed solely to satisfy hospital pre-admission requirements.

18-004.33D Anesthesiology

18-004.33D1 Professional Component: The Department covers, as a physician's service, the professional component of anesthesiology services provided by a physician to an individual patient if the conditions in 471 NAC 18-004.33A1 are met. The professional component must be claimed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Claims for these services must indicate actual time in one-minute increments.

18-004.33D2 Medical Direction of Four or Fewer Concurrent Procedures: The professional component for the physician's medical direction of concurrent anesthesiology services provided by qualified anesthetists, such as certified registered nurse anesthetists (CRNA's), is covered as a physician's service when the services meet the requirements listed in 471 NAC 18-004.33A1 and the following additional requirements:

1. For each patient, the physician -
   a. Performs and documents a pre-anesthetic examination and evaluation;
   b. Prescribes the anesthesia plan;
   c. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
   d. Ensures that any procedures in the anesthesia plan that s/he does not perform are performed by a qualified individual;
   e. Monitors the course of anesthesia administration at frequent intervals;
   f. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
   g. Provides indicated post-anesthesia care; and
2. The physician directs no more than four anesthesia procedures concurrently, and does not provide any other services while directing the concurrent procedures (see 471 NAC 18-004.33D2a).

The physician's medical direction of four or fewer concurrent anesthesia procedures is considered a professional component and must be billed on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837).

18-004.33D2a Other Services Provided While Directing Concurrent Procedures: A physician who is directing concurrent anesthesia services for four or fewer surgical patients must not ordinarily be involved in providing additional services to other patients. The following situations are examples of services that do not constitute a separate service for determining medical direction in item 2 of 471 NAC 18-004.33D2:

1. Addressing an emergency of short duration in the immediate area;
2. Administering an epidural or caudal anesthetic to ease labor pain;
3. Periodic, rather than continuous, monitoring of an obstetrical patient;
4. Receiving patients entering the operating suite for the next surgery;
5. Checking or discharging patients in the recovery room; or
6. Handling scheduling matters.

If the physician leaves the immediate area of the operating suite for longer than short durations, devotes extensive time to an emergency case, or is otherwise not available to respond to the immediate needs of surgical patients, the physician's services to the surgical patient are supervisory in nature and are considered a technical component; therefore, these services must be billed as the technical component by the hospital.

18-004.33D3 Supervision of More Than Four Concurrent Procedures: If the physician is involved in providing supervision for more than four concurrent procedures or is performing other services while directing four or fewer concurrent procedures, the physician's services are considered a technical component of hospital services. The physician shall ensure that a qualified individual performs any procedure in which the physician does not personally participate. The physician's personal services up to and including induction are considered the professional component.

18-004.33D4 Standby Anesthesia Services: A physician's standby anesthesia services are covered when the physician is physically present in the operating suite, monitoring the patient's condition, making medical judgments regarding the patient's anesthesia needs and ready to furnish anesthesia services to a specific patient who is known to be in potential need of services. The professional component must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

18-004.33D5 Claims for Payment: When a physician bills for anesthesia services, the physician shall certify with the claim, as appropriate, that -

1. The services were personally provided by the physician to the individual patient; or
2. When the physician provided medical direction for CRNA services, the number of concurrent services directed is indicated by the appropriate modifier.

To make payment for anesthesia services for sterilizations, a properly completed and legible copy of Form MMS-100, "Sterilization Consent Form" (see 471-000-109) must be on file with the Department.

For a hysterectomy, a properly completed copy of Form MMS-101, signed and dated by the client stating she was made aware before the surgery that the surgery would result in sterility must be on file with the Department before payment can be made.

See 471 NAC 18-004.07 for exceptions to informed consent forms for hysterectomies.

Claims for these services must indicate actual time in one-minute increments.

Also see 471 NAC 18-004.18 and 18-004.47.

18-004.33D6 Payment for Anesthesiology Services: NMAP pays for covered anesthesiology 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 for service.

NMAP does not make additional reimbursement for emergency and risk factors.

Also see 471 NAC 18-004.47.

18-004.33E Laboratory

18-004.33E1 Professional Component: The Department covers as a physician's service the professional component of laboratory services provided by a physician to an individual patient only if the services meet the requirements listed in 471 NAC 18-004.33A1 and are -

1. Anatomical pathology services;
2. Consultative pathology services, which must -
   a. Be requested by the patient's attending physician;
   b. Relate to a test result that lies outside the clinically significant normal or expected range in view of the patient's condition;
   c. Result in a written narrative report included in the patient's medical record; and

d. Require the exercise of medical judgment by the consulting physician; or

3. Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient.

18-004.33E2 Technical Component: Clinical laboratory services provided to hospital inpatients, outpatients, and non-patients are routinely performed by non-physicians (i.e., medical technologists or laboratory technicians) or by automated laboratory equipment. These clinical laboratory services do not require performance by a physician and are considered the technical component; there is no professional component for these services. The technical component must be billed by the hospital on the appropriate claim form or electronic format. (See claim submission table at 471-000-49).

18-004.33E3 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.

18-004.33E4 Billing and Payment for Inpatient Hospital Anatomical Pathology Services: Payment for the technical component of anatomical pathology is included in the hospital's payment.

The pathologist shall claim the professional component of anatomical pathology on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate HCPCS procedure code and modifier. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

Exception: If an anatomical pathology specimen is obtained from a hospital inpatient but is referred to an independent laboratory or the pathologist of a second hospital's laboratory, the independent lab or the pathologist of the second hospital's laboratory to which the specimen has been referred may claim payment for the total service (professional or 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.

18-004.33E5 Billing and Payment for Outpatient Hospital Anatomical Pathology Services: The hospital shall claim the technical component on the appropriate claim form or electronic format (see claim submission table 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

The pathologist shall claim the professional component on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) using the appropriate HCPCS procedure code and modifier. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

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 Medicaid.
3. Non-Patient Services: Payment is made according to the fee schedule determined by 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 Medicaid fee schedule for clinical laboratory services to cover the total service (professional and technical components). (See 471-000-520).

18-004.33E10 Clinical Lab Consultation: A physician may claim a clinical lab consultation if the service -

1. Is requested by the patient's attending physician;
2. Relates to a test result that lies outside the clinically significant normal or expected range for the patient's condition;
3. Results in a written narrative report which is included in the patient's record; and
4. Requires the exercise of medical judgment by the consulting physician.

The physician shall claim a clinical lab consultation using the appropriate HCPCS procedure codes.

18-004.33E11 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.

18-004.33F Radiology: All radiology services have a technical component and a professional component (physician interpretation). The professional and technical component of hospital services must be separately identified for billing and payment.

18-004.33F1 Professional Component: The professional component of radiology services provided by a physician to an individual patient is covered as a physician's service when the services meet the requirements listed in 471 NAC 18-004.33A1 and the services are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures. The professional component must be billed on the appropriate claim or electronic format (see claim submission table 471-000-49).

18-004.33F2 Technical Component: The technical component of radiology services to the hospital, such as administrative or supervisory services or services needed to produce the x-ray films or other items that are interpreted by the radiologist, must be billed by the hospital on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

18-004.33F3 Billing and Payment for Inpatient Radiology Services: Payment for the technical component of inpatient radiology services is included in the hospital's payment.

Physicians must bill the professional component of inpatient radiology services on the appropriate claim form or electronic format (see claim submission table 471-000-49) using the appropriate HCPCS procedure code with modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.33F4 Billing and Payment for Outpatient Radiology Services: The hospital must claim the technical component of outpatient radiology services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

The physician must bill the professional component on the appropriate claim form or electronic format (see claim submission table 471-000-49) using the appropriate HCPCS procedure code with the modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.33F5 Billing and Payment for Non-Patient Radiology Services: A non-patient is an individual receiving services who is neither an inpatient nor an outpatient. If a radiology procedure is performed for a non-patient, the hospital must claim the total component on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made according to 471 NAC 10-010.06 ff.

If the radiology department is leased and the service is provided to a non-patient, the radiologist must claim the total service (both technical and professional components) on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Payment is made is made according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.34 Non-Physician Care Providers: Nebraska Medicaid covers services provided by "non-physician care providers" under the following conditions:

1. The non-physician care provider must meet the following definition: An individual trained to assist or act in the place of a physician, such as physician assistant, medical specialty assistant, medical services assistant, clinical associate, surgical assistant (graduate physician assistant who has completed a CAHEA accredited surgical residency program), who has received the training required by the specific title;
2. The service provided by the non-physician care provider must be within the scope of practice as defined by state law; and
3. The non-physician care provider must provide the services under a practice agreement between the non-physician care provider and his/her supervising physician, and must be approved by the Board of Medicine and Surgery in the Nebraska Department of Health and Human Services or the appropriate licensing agency in the state in which s/he provides the services.

18-004.34A Physician Assistant Services: Nebraska Medicaid covers physician assistant services under the following guidelines: To participate in Nebraska Medicaid, the physician assistant must be licensed by the Nebraska Department of Health and Human Services Division of Public Health as required by 172 NAC 90. The written scope of practice agreement between the physician assistant and the physician must be on file as required by Neb. Rev. Stat. § 38-2050. The physician assistant is approved for enrollment under a group provider agreement with the physician with whom s/he has a practice agreement. Nebraska Medicaid covers those services determined to be medically necessary.

18-004.34B Payment for Services Provided by Physician Assistants: Nebraska Medicaid covers services of physician assistants to the extent that they are legally authorized to practice in Nebraska. Payment to physician assistants is made to the physician provider group number with whom the physician assistant is enrolled. When payment is made to the physician group, the physician is responsible for payment to the physician assistant. Payment for physician assistant services is made according to 471 NAC 18-006. Claims for services provided by physician assistants must be submitted on Form CMS-1500 or the standard electronic Health Care Claim:

Professional transaction (ASC X12N 837) under the physician assistant's provider group number.

18-004.34C: Nebraska Medicaid will not make payments to physicians assistants who are employed by a hospital.

18-004.35 (Reserved)

18-004.36 Initial Certification (SNF, ICF, and ICF/MR): Facility staff shall obtain a signed and dated Form DM-5 that corresponds to the nursing home admission date or the date eligibility is determined. Form DM-5 serves as the certification required by federal regulations. The physician shall examine the client before completing the certification, within the following time frames:

1. For SNF Clients: The client must have a physical examination within 48 hours (two working days) after admission unless an examination was performed within five days before admission.
2. For ICF Clients: The client must have a recent physical examination (within 30 days before admission or the date eligibility was determined, or within 48 hours [two working days] after admission or the date eligibility was determined.

The physician may bill the Department for an annual nursing home physical exam service, regardless of the extent of the exam. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

If the admission is a facility-to-facility transfer, local office staff shall obtain a copy of the client's annual history and physical, if it is current to the client's condition (within 30 days before the transfer), and attach it to the signed and dated Form DM-5. The physician may bill the Department for a recertification service. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.36B Annual Physical Examination: The Nebraska Department of Health and Human Services Finance and Support requires that all long term care facility residents have an annual physical examination. The physician, based on his/her authority to prescribe continued treatment, determines the extent of the examination for NMAP clients based on medical necessity. The Department does not cover routine laboratory and radiology services which are not directly related to the patient's diagnosis and treatment; however, for the annual physical exam, a CBC and urinalysis are not considered "routine" and are reimbursed based on the physician's orders when noted on the claim that these services were performed for an annual physical exam for a nursing home client. The results of the examination must be recorded in the client's medical record.

If the annual physical examination is performed solely to meet the requirement of the Department, the physician shall submit the claim to the Department on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The Department limits reimbursement for this service to the amount allowed under the Nebraska Medicaid Practitioner Fee Schedule.

18-004.36C Medicare Coverage: If a physical examination is performed for diagnosis and/or treatment of a specific symptom, illness, or injury and the client has Medicare coverage, the physician shall submit the claim through the usual Medicare process. This applies to all physicians' visits in a long term care facility.

18-004.36D Physicians' Services for Skilled Nursing Facility (SNF) Clients

18-004.36D1 Physician's Visits: The physician shall see the SNF client whenever necessary, but at least once every 30 days for the first 90 days following admission. After the 90th day following admission, an alternate schedule for physician's visits not to exceed 60 days may be adopted if the attending physician determines, and justifies in the client's medical record, that the client's condition does not require visits at 30-day intervals. The facility's Utilization Review Committee shall approve the alternate schedule.

At the time of each visit, the physician shall document the visit in the client's medical record, and write and sign a progress note on the client's condition.

18-004.36D1a Billing for Physicians' Visits to SNF Clients: When billing for a physician's visit, the physician shall use the appropriate HCPCS procedure code for a nursing home visit.

Because the Department requires these services, they may not be covered by Medicare.

18-004.36D2 Review of Plan of Care: The physician and facility staff involved in the SNF client's care shall review each plan of care every 60 days. This should be done in conjunction with a physician's visit or recertification.

18-004.36D3 Recertification: For SNF clients, the physician or the physician's assistant shall recertify in writing the client's continued need for the current level of care every 30 days for the first 90 days and every 60 days thereafter, and at any time the client requires a different level of care.

The physician's assistant or nurse practitioner may recertify the client's need under the general supervision of a physician when the physician formally delegates this function to the physician's assistant.

The physician, the physician's assistant, or nurse practitioner shall sign, or stamp and initial, the recertification clearly identifying himself/herself.

The physician, physician's assistant, or nurse practitioner shall date the recertification at the same time it is signed.

Facility staff shall maintain the recertification in the client's medical record in the facility or building where the client resides.

18-004.36D3a On-Site Recertification: The physician shall record recertifications accomplished by on-site visits to the facility in the client's record. The physician is paid according to the Nebraska Medicaid Practitioner Fee Schedule. The physician shall use the appropriate HCPCS procedure code for nursing home visits when billing NMAP for this service.

18-004.36E Physicians' Services for Clients in Intermediate Care Facilities (ICF's) and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's)

18-004.36E1 Physician's Visits: The physician shall see the ICF client whenever necessary, but at least once every 60 days, unless the physician determines that the frequency is not necessary and establishes an alternate schedule not to exceed one year, and records the reason in the medical record. The physician must actually see the patient to claim the service.

At the time of each visit, the physician shall document the visit in the client's medical record, and write and sign a progress note on the client's condition.

18-004.36E1a Billing for Physicians' Visits to ICF and ICF/MR Clients: When billing for a physician's visit, the physician shall use the appropriate HCPCS procedure code. The physician shall submit following statements on or with the claim: "60-day (or alternate schedule) intermediate examination."

Because the Department requires these services, they may not be covered by Medicare.

18-004.36E2 Review of Plan of Care: The interdisciplinary team, which includes the physician, shall review each ICF plan of care every 90 days. This should be done in conjunction with recertification and is not reimbursed separately.

18-004.36E3 Recertification: The physician shall recertify in writing the client's continued need for the ICF/MR level of care at least once every 365 days, and at any time the client requires a different level of care.

The extended recertification period in no way indicates that one year is the appropriate length of stay for a client in an ICF/MR. The interagency team responsible for the client's care determines the client's length of stay.

The physician's assistant or nurse practitioner may recertify the client's need under the general supervision of a physician when the physician formally delegates this function to the physician's assistant or nurse practitioner.

The physician, the physician's assistant, or nurse practitioner shall sign, or stamp and initial, the recertification clearly identifying himself/herself.

The physician, physician's assistant, or nurse practitioner shall date the recertification at the same time it is signed.

Facility staff shall maintain the recertification in the client's medical record in the facility or building where the client resides.

18-004.36E3a On-Site Recertification: The physician shall record recertifications accomplished by on-site visits to the facility in the client's record. The physician is paid according to the Nebraska Medicaid Practitioner Fee Schedule. The physician shall use the appropriate HCPCS procedure code for nursing home visits when billing NMAP for this service.

18-004.37 Rural Health Clinics: Rural health clinic services are defined as the following services provided by a rural health clinic that is certified in accordance with 42 CFR Part 481:

1. Services provided by a physician within the scope of practice of his/her professional under state law (and with NMAP guidelines), if the physician provides the services in the clinic, or the services are provided away from the clinic and the physician has an agreement with the clinic providing that s/he will be paid by the clinic for the service;
2. Services provided by a mid-level practitioner if the services are provided in accordance with 42 CFR 405.2414(a); and
3. Services and supplies that are provided incident to professional services provided by a physician or a mid-level practitioner.

18-004.38 Telephone Consultations: NMAP does not make payment for telephone calls to or from a patient, pharmacy, nursing home, or hospital. NMAP may make payment for telephone consultations with another physician if the name of the consulting physician is indicated on or in the claim.

18-004.39 Definitions and Terms of Commonality: Current Procedural Terminology - Fourth Edition (CPT-4) contains terms and phrases common to the practice of medicine. Claims for physicians' services must be coded according to the definitions in the CPT-4. The provider shall submit copies of NMAP clients' medical records which NMAP may require to document the level of care provided when the Department requests them. If the requested documentation is not provided or is insufficient in contents, payment may be withheld or refunded. NMAP recognizes the definitions and reporting requirements of the CPT, but coverage is based on regulations in this title.

18-004.40 Medical Transplants: NMAP covers transplants including donor services that are medically necessary and defined as non-experimental by Medicare. If no Medicare policy exists for a specific type of transplant, the Medical Director of the Medicaid Division shall determine whether the transplant is medically necessary or non-experimental.

Notwithstanding any Medicare policy on liver or heart transplants, the Nebraska Medical Assistance program covers liver or heart transplantation when the written opinions of two physicians specializing in the specific transplantation state that a transplant is medically necessary as the only clinical, practical, and viable alternative to prolong the patient's life in a meaningful, qualitative way and at a reasonable level of functioning.

NMAP is the payor of last resort.

NMAP requires prior authorization of all transplant services before the services are provided (see 471 NAC 18-004.40D). An exception may be made for emergency situations, in which case verbal approval is obtained and the notification of authorization is sent.

18-004.40A Services for an NMAP-Eligible Donor: NMAP covers medically necessary services for the NMAP-eligible donor to an NMAP-eligible client. The services must be directly related to the transplant.

NMAP covers laboratory tests for NMAP-eligible prospective donors. The tests must be directly related to the transplant.

18-004.40B Services for an NMAP-Ineligible Donor: NMAP covers medically necessary services for the NMAP-ineligible donor to an NMAP-eligible client. The services must be directly related to the transplant and must directly benefit the NMAP transplant client. Coverage of treatment for complications related to the donor is limited to those that are reasonably medically foreseeable.

NMAP covers laboratory tests for NMAP-ineligible prospective donors that directly benefit the NMAP transplant client. The tests must be directly related to the transplant.

NMAP does not cover services provided to an NMAP-ineligible donor that are not medically necessary or that are no directly related to the transplant.

NMAP requires prior authorization of all transplant services before the services are provided (see 471 NAC 18-004.20D).

18-004.40C Billing for Services Provided to an NMAP-Ineligible Donor: Claims for services provided to an NMAP-ineligible donor must be submitted under the NMAP-eligible client's case number. There must be a notation with the claim that these services were provided to the NMAP-ineligible donor on the client's behalf.

18-004.40D Prior Authorization: Physicians shall request prior authorization before performing any transplant service or related service. The physician shall submit requests for NMAP prior authorization in writing or electronically using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instructions at 471-000-50). Physicians shall obtain prior authorization prior to providing the service from -

The Medical Director
Medicaid Division
Nebraska Department of Health and Human Services Finance and Support
301 Centennial Mall South
P. O. Box 95026
Lincoln, NE 68509

The request must include at a minimum -

1. The patient's name, age, diagnosis, pertinent past medical history and treatment to this point, prognosis with and without the transplant, and the procedure(s) for which the authorization is requested;
2. The patient's Nebraska Medicaid number;
3. Name of hospital, city, and state where the service(s) will be performed. The Department's policy regarding out of state services remains in effect. See 471 NAC 1-004.04;
4. Name of physician(s) who will perform the surgery if other than physician requesting authorization; and
5. If authorization is requested to the above information, two physicians shall also supply the following:
   a. The screening criteria used in determining that a patient is an appropriate candidate for a liver or heart transplant;
   b. The results of that screening for this patient (i.e., the patient is eligible to be placed on "waiting list" in which the only remaining criteria is organ availability); and
   c. A statement by each physician -
      (1) Recommending the transplant; and
      (2) Certifying and explaining why a transplant is medically necessary as the only clinical, practical, and viable alternative to prolong the client's life in a meaningful, qualitative way and at a reasonable level of functioning.

The Nebraska Department of Health and Human Services Finance and Support, Medical Director, shall send a response to the provider(s) advising them of the approval or denial of Medicaid payment of the requested transplant.

18-004.40E Payment for Liver or Heart Transplant Services: Only those services which are determined by the NMAP to be medically necessary and appropriate will be considered for Medicaid payment. The Department reserves the right to request any medical documentation from the patient's record to support and substantiate claims submitted to the Department for payment. These records may include but are not limited to office records, hospital progress notes, doctor's orders, nurses notes, consultative reports, hospital admission history and physical, and discharge summary.

18-004.40E1 Inpatient Hospital Services: Payment basis for inpatient hospital services is established under 471 NAC 10-010.05.

Procurement costs include removal of organ, transportation, and associated costs. These costs must be billed by the hospital on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) and separately identified on the Medicare cost report.

Payment of the technical component of inpatient laboratory and diagnostic and therapeutic radiology services will be included in the hospital’s payment for inpatient services.

18-004.40E2 Limitations to Payment for Inpatient Hospital Services: NMAP will pay the special inpatient hospital rate for no more than five days before the liver or heart transplant until discharge to an alternate level of care (i.e., ambulatory room and board). The liver or heart transplant recipient must meet the criteria established at 471 NAC 18-004.40D. and must be registered as an inpatient before the Department pays this rate.

18-004.40E3 Ambulatory Room and Board: The Department may cover ambulatory room and board services for liver or heart transplant patients (for the client and an attendant, if necessary).

18-004.40E4 Outpatient Hospital Services: All services not provided on an inpatient basis will be paid at the rates established under NMAP. For laboratory and radiology services, see the elimination of combined billing regulations at 471 NAC 18-004.33.

18-004.40E5 Physician Services: Surgeon(s) services will be paid according to the Nebraska Medicaid Practitioner Fee Schedule. This fee will include two weeks' routine post-operative care by the designated primary surgeon. Payment for routine post-operative care will not be made to other members of the surgical team.

Services provided after the two-week post-operative period may be billed on a fee-for-service basis. Also see 471 NAC 18-004.19.

Physician services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

18-004.41 Itinerant Physician Visits: NMAP covers non-emergency physician visits provided in a hospital outpatient setting if the services are -

1. Provided by an out-of-town specialist who has a contractual agreement with the hospital. NMAP does not consider general practitioners or family practitioners to be specialists; and
2. Determined to have been provided in the most appropriate place of service (see 471 NAC 2-006.01).

The hospital room charge must be billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The physician's service must be coded as an office visit and billed on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). The physician will be paid at the rate for the appropriate level of office visit.

18-004.42 Nurse-Midwife Services: The Nebraska Medical Assistance Program covers nurse-midwife services under the following guidelines.

To participate in the Nebraska Medical Assistance Program, the nurse-midwife must be certified by the Nebraska Department of Health and Human Services Regulation and Licensure. The practice agreement between the nurse-midwife and the physician must be on file with the Department of Health and Human Services Regulation and Licensure. The nurse-midwife is approved for enrollment in NMAP under a group provider agreement with the physician with whom s/he has a practice agreement.

NMAP covers nurse-midwife services that are medically necessary in accordance with his/her scope of practice as defined by law.

NMAP does not cover routine office visits to a physician when a nurse-midwife is providing complete obstetrical care, unless documentation of medical necessity for the physician's office visit is submitted.

Payment for nurse-midwife services is made to the group with whom the nurse-midwife has a practice agreement; the group is then responsible for payment to the nurse-midwife. Payment for nurse-midwife services is made at the lower of -

1. The provider's submitted charge; or
2. The Medicaid allowable amount for the procedure code billed.

Claims for nurse-midwife services must be submitted on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). NMAP covers pre-natal care, delivery, and post-partum care as a "package" service. Auxiliary services, such as pre-natal classes and home visits, are not paid as separate line items.

18-004.43 Nurse-Practitioner Services: The Nebraska Medical Assistance Program covers nurse-practitioner services under the following guidelines:

To participate in the Nebraska Medical Assistance Program, the nurse-practitioner must be certified by the Nebraska Department of Health and Human Services Regulation and Licensure. The practice agreement between the nurse-practitioner and the physician must be on file with the Nebraska Department of Health Health and Human Services Regulation and Licensure. The nurse-practitioner is approved for enrollment under a group provider agreement with the physician with whom s/he has a practice agreement.

NMAP covers nursing assessments as nurse-practitioner services. The services must be medically necessary. A nursing assessment includes the physical and psychological status of individuals and families by means of health history, and physical examinations as needed for the physician to establish diagnosis and institute treatment of a physical condition. The initial medical diagnosis and institution of a plan of therapy or referral may also be covered within the nurse-practitioner's area of specialization.

The Nebraska Medical Assistance Program does not cover any other services provided by nurse-practitioners.

Payment for nurse-practitioner services is made at the lower of -

1. The provider's submitted charge; or
2. The Medicaid allowable amount for the procedure code billed.

Claims for nurse-practitioner services must be submitted on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) according to claim submission instructions in the Appendix of this Title.

18-004.43A Certified Pediatric Nurse Practitioners and Certified Family Nurse Practitioners: For services provided on or after July 1, 1990, NMAP covers services provided by certified pediatric nurse practitioners and certified family nurse practitioners under the following guidelines.

To participate in the Nebraska Medical Assistance Program, the certified pediatric nurse practitioner or certified family nurse practitioner must be certified by the Department of Health and Human Services Regulation and Licensure. The practice agreement between the certified pediatric nurse practitioner or certified family nurse practitioner must be on file with the Department of Health and Human Services Regulation and Licensure. The certified pediatric nurse practitioner or certified family nurse practitioner is approved for enrollment in NMAP under an independent provider agreement or the provider agreement of the physician with whom s/he has a practice agreement.

18-004.43A1 Standards for Certified Pediatric Nurse Practitioners: A certified pediatric nurse practitioner (CPNP) is a registered professional nurse who must -

1. Be currently licensed to practice as a registered professional nurse in the state in which the services are provided;
2. Meet the applicable state requirements for qualification of pediatric nurse practitioners, or nurse practitioners generally in the state in which the services are provided; and
3. Be currently certified as a pediatric nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates.

18-004.43A2 Standards for Certified Family Nurse Practitioners: A certified family nurse practitioner (CFNP) is a registered professional nurse who must -

1. Be currently licensed to practice as a registered professional nurse in the state in which the services are provided;
2. Meet the applicable state requirements for qualification of family nurse practitioners, or nurse practitioners generally in the state in which services are provided; and
3. Be currently certified as a family nurse practitioner by the American Nurses' Association.

18-004.43A3 Payment for Services Provided by Certified Pediatric Nurse Practitioners and Certified Family Nurse Practitioners: NMAP covers services of CPNP's and CFNP's to the extent that they are legally authorized to practice in Nebraska.

Payment to CPNP's and CFNP's is made to the nurse practitioner or to the physician with whom the nurse practitioner has a practice agreement. If payment is made to the physician, the physician is then responsible for payment to the nurse practitioner. Payment for CPNP or CFNP services is made at the lower of -

1. The provider's submitted charge; or
2. A percentage, determined by the Department, of the amount allowable under the Nebraska Medicaid Practitioner Fee Schedule if the service was provided by a physician.

Claims for CPNP and CFNP services must be submitted on Form CMS-1500 according to instructions in 471-000-62 or on the appropriate electronic transaction (see Claim Submission Table at 471-000-49).

18-004.44 Infant Apnea Monitors: NMAP covers rental of home infant apnea monitors for infants with medical conditions that require monitoring due to a specific medical diagnosis only if prescribed by and used under the supervision of a physician. Proper infant evaluation by the physician and parent/caregiver training must occur before placement of infant apnea monitor. Parent/caregiver training is not reimbursed as a service separate from infant apnea monitor rental.

18-004.44A Medical Guidelines for the Placement of Home Infant Apnea Monitors: NMAP covers home infant apnea monitoring services for infants who meet one of the following criteria. NMAP defines infancy as birth through completion of one year of age.

1. Infants with one or more apparent life-threatening events (ALTE's) requiring mouth-to-mouth resuscitation or vigorous stimulation. ALTE is defined as an episode that is frightening to the observer and characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually limpness), choking, or gagging. In some cases, the observer fears the infant has died;
2. Symptomatic preterm infants;
3. Siblings of one or more SIDS victims; or
4. Infants with certain diseases or conditions, such as central hypoventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants of substance-abusing mothers, or infants with less severe ALTE's.

18-004.44A2 Removing the Infant from the Monitor: Criteria for removing infants from home infant apnea monitoring must be based on the infant's clinical condition. A monitor may be discontinued when ALTE infants have had two-three months free of significant alarms or apnea where vigorous stimulation or resuscitation was not needed. Evaluating the infant's ability to tolerate stress (e.g., immunizations, illness) during this time is advisable.

18-004.44C Approval of Home Infant Apnea Service Providers: NMAP covers rental of home infant apnea monitors and related supplies only from approved providers. To ensure all home apnea monitoring needs of infants are met, the Department requires the development of a home infant apnea monitor "Coordination Plan." The "Coordination Plan is not an individual patient plan; it is an overall program outline for the delivery of home apnea monitoring services. The "Coordination Plan" must be submitted to the Medicaid Division for approval before providing home infant apnea monitor and monitor supplies.

Note: Physicians may not bill for rental of apnea monitoring equipment or related supplies.

18-004.44D Documentation Required After Initial Rental Period: Monitor rental exceeding the original two-month prescription period requires that an updated physician's narrative report of patient progress and a statement of continued need accompany the claim. A new progress report is required every two months. The report must include -

1. The number of apnea episodes during the previous prescription period;
2. The results of any tests performed during the previous prescription period;
3. Additional length of time needed; and
4. Any additional information the physician may wish to provide.

18-004.44E Limitations on Coverage of Apnea Monitor Equipment and Supplies: NMAP does not cover monitors that do not use rechargeable batteries.

NMAP does not make separate payment for remote alarms. If provided, payment for a remote alarm is included in the monitor rental.

Apnea monitor belts, lead wires, and reusable electrodes are covered for rented apnea monitors.

18-004.44E1 Pneumocardiograms: Pneumocardiograms are covered only when physician ordered to determine when the infant may be removed from the monitor. Payment for rental of an ECG/respirator recorder includes all accessories required to obtain a valid pneumocardiogram. Payment for durable medical equipment does not include analysis and interpretation of tests. This service must be billed by the physician performing the service.

18-004.45 Home Phototherapy: NMAP covers rental of home phototherapy (bilirubin) equipment for infants who require phototherapy when neonatal hyperbilirubinemia is the infant's sole clinical problem and only if prescribed by and used under the supervision of a physician. Prior authorization is not required for this service.

18-004.45A Medical Guidelines for the Placement of Home Phototherapy Equipment: NMAP recognizes the Nebraska Chapter of the American Academy of Pediatric's Standard of Care for home phototherapy. Home phototherapy services will be covered when the following conditions are met:

1. Infant evaluation by the physician and parent/caregiver training occurs before placement of equipment;
2. Documentation must be available with the supplier to show that -
   a. The physician certifies that the infant's condition meets the medical criteria outlined below and that the parent/caregiver is capable of administering home phototherapy; and
   b. The provider certifies that the parent/caregiver has been adequately trained and consent forms used by the provider have been signed; and
3. The infant's medical condition meets the following criteria:
   a. Greater than or equal to 37 weeks gestational age and birth weight greater than 2,270 gms (5 lbs);
   b. Greater than 48 hours of age;
   c. Bilirubin levels at initiation of phototherapy (greater than 48 hours of age) are 14-18 mgs per deciliter;
   d. Direct bilirubin level less than 2 mgs per deciliter;
   e. History and physical assessment (if the service begins immediately upon discharge from the hospital, the newborn discharge exam will suffice); and
   f. Required laboratory studies to include CBC, blood type on mother and infant, direct Coombs, direct and indirect bilirubin (additional laboratory data may be requested at physician's discretion). At a minimum, one bilirubin level must be obtained daily while the infant is receiving home phototherapy.

18-004.45B Discontinuing Home Phototherapy: Home phototherapy services will not be covered if the bilirubin level is less than 12 mgs. at 72 hours of age or older.

18-004.45C Approval of Home Phototherapy Providers: NMAP covers rental of home phototherapy equipment provided by approved providers. Physicians will not be approved as home phototherapy providers.

18-004.45D Documentation Required after Initial Rental Period: Home phototherapy services exceeding a three-day period require a physician's narrative report of patient progress and statement of continued need submitted with the claim.

18-004.45E Limitations on Coverage of Home Phototherapy Services: Payment for home phototherapy services does not include physician's professional services or laboratory and radiology services related to home phototherapy. These services must be billed by the physician or laboratory performing the service.

18-004.46 Ambulatory Uterine Monitors: NMAP covers rental of ambulatory uterine monitors. The monitor must be prescribed by and used under the supervision of a physician and provided by a medical supplier. Prior authorization is not required for this service.

18-004.46A Medical Guidelines for the Placement of Ambulatory Uterine Monitors: Ambulatory uterine monitors will be covered when the following conditions are met:

1. Evaluation by the physician and training on use of the monitor occurs prior to placement of the monitor;
2. Documentation must be available with the supplier to show that -
   a. The physician certifies that the client meets the medical criteria outlined below; and
   b. The provider certifies that the client has been adequately trained; and
3. The client must be at high risk for preterm labor and delivery and must be a candidate for tocolytic therapy. The pregnancy must be greater than 20 weeks gestation and the client must meet one of the medical conditions listed below:
   a. Recent preterm labor with hospitalization and discharge on tocolytic therapy;
   b. Multiple gestation;
   c. History of preterm delivery;
   d. Anomalies of the uterus;
   e. Incompetent cervix;
   f. Previous cone biopsy;
   g. Polyhydramnios; or
   h. Diethylstilbestrol exposure.

Others at high risk for preterm labor and delivery may be covered for this service upon approval by the Department's Medical Director through written communication from the client's physician (preferably in consultation with a perinatologist).

18-004.46B Discontinuing the Monitor: Ambulatory uterine monitors will not be covered after completion of the 36th week of pregnancy.

18-004.46C Approval of Ambulatory Uterine Monitor Providers: NMAP covers rental of ambulatory uterine monitors provided by approved providers. Physicians are not approved as providers of ambulatory uterine monitors.

18-004.46D Limitations on Coverage of Ambulatory Uterine Monitors: NMAP's allowable fee includes all equipment, supplies, and services necessary for the effective use of the monitor. This does not include medications or physician's professional services. Rental is allowable only when the client is at home and appropriately using the monitor.

18-004.47 Services of Certified Registered Nurse Anesthetists (CRNA's): The Nebraska Medical Assistance Program (NMAP) covers the services of CRNA's under the following conditions.

18-004.47A Provider Participation: A certified registered nurse anesthetist (CRNA) is a registered nurse who is licensed by the Department of Health and Human Services Regulation and Licensure and is currently certified by the Council on Certification of Nurse Anesthetists or Council on Recertification of Nurse Anesthetist, or has graduated since August 1987 from a nurse anesthesia program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

To participate in NMAP, the CRNA shall submit a completed Form MC-19, "Medical Assistance Provider Agreement," with a copy of his/her credentials attached, to the Nebraska Department of Health and Human Services Finance and Support for enrollment in NMAP. NMAP shall verify eligibility/credentials before initial enrollment.

18-004.47A1 Provider Numbers: CRNA's may bill NMAP directly for their services or have payment made to an employer or entity under which they have a contract (i.e., physician, hospital, or ambulatory surgical center (ASC)). When the provider is enrolled, NMAP will issue a provider number to the CRNA. A separate Form MC-19 and provider number is required for each of the following:

1. An individual CRNA billing directly (one provider number);
2. A group of CRNA's billing directly (one provider number to cover all in the group); or
3. A physician, hospital, or ambulatory surgical center (ASC) who is billing for the services of CRNA's who are employed the physician, hospital, or ASC (one provider number to cover all employees).

18-004.47B Claims for CRNA Services: Claims for CRNA services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Exception: Rural hospitals that have been exempted by their Medicare fiscal intermediary for CRNA billing shall follow the Medicare billing requirements.

When anesthesia services are provided by an anesthesiologist and a CRNA at the same time, NMAP will recognize for payment only those services provided by the anesthesiologist.

NMAP does not make additional reimbursement for emergency and risk factors.

When multiple surgical procedures are performed at the same time, the CRNA shall bill only for the major procedure. NMAP does not make payment for CRNA services for secondary procedures.

18-004.47C Payment for CRNA Services: These services are paid according to the Nebraska Medicaid Practitioner Fee Schedule.

18-004.48 and 18-004.49 (Reserved)

18-004.50 Feeding and Swallowing Clinic Services: The Nebraska Medical Assistance Program covers feeding and swallowing clinic services under the following conditions.

This service is covered for those clients with medical conditions that make feeding and swallowing difficult (dysphagia). The service is covered when the client is referred by a physician for a medical evaluation. The purpose of the evaluation is to assess the client's current status and potential for improvement and to develop a plan of care for the client.

The initial evaluation is performed by an interdisciplinary team. The interdisciplinary team must, at a minimum, include, but is not limited to, a nurse, occupational therapist, speech pathologist, nutritionist, psychologist, and radiologist. The team must be under the direction of a physician.

Follow-up visits must be available in a frequency adequate to meet patient needs and program objectives.

18-004.50A Provider Enrollment: The provider shall submit a completed Form MC-19 along with a program overview that demonstrates the following components of service are available within the program:

1. Interdisciplinary team evaluation which provides information to team members on the patient's medical status and nutrition/diet status and also addresses feeding and behavioral concerns. In the process of the interdisciplinary team evaluation, the team must review and consider information from other available resources, e.g., attending/referring physician, nursing home, school;
2. Assessment by the occupational therapist of the client's tone and posture to determine seating/positioning for feeding and for the videoflouroscopy procedure;
3. Examination by the speech pathologist to assess the client's oral structures and clinical swallowing evaluation;
4. A videoflousoscopy (swallow study) to determine conditions that are most favorable for a safe, efficient swallow and management of feeding problems.
5. Assessment of oral motor function (i.e., use of lips, jaws, cheeks, and tongue) and feeding behaviors. Depending on the needs of the client, some or all of the team members may be involved in this component. This assessment includes presentation of a variety of amounts and types of foods and liquids to the clients to provide additional information used to establish therapeutic intervention;

6. Conference by team members to review finding, establish priorities, and coordinate treatment and follow-up recommendations; and
7. Presentation of plan of care to the client/family, including instruction, demonstration, and written recommendations for feeding procedures at home and in other environments. This may include school, nursing home, or others involved in the patient's care.

After the initial visit, the team formulates a formal written report and sends copies to the client/family, the referring physician, and others designated by the client/family and/or by the Department.

The team contacts, by telephone, the referring physician and, if appropriate, other medical professionals, to provide immediate feedback to the team on primary findings and recommendations.

18-004.50B Follow-Up Calls: Follow-up telephone call are made after the initial evaluation and are included in the cost of the evaluation, as follows:

1. Within 48 hours after the evaluation, a team members calls the client/family to answer questions and provide clarification, if needed of any information presented during the initial visit.
2. Two to four weeks after the initial visit, a follow-up call is made to ask about progress and/or problems in following the team recommendations;
3. Ongoing telephone communication is maintained with the client/family and/or referring physician to facilitate implementation of the team recommendations.

18-004.50C Billing and Payment: NMAP defines the services as follows:

Swallowing disorders assessment, comprehensive: This includes, at a minimum, comprehensive evaluation by the occupational therapist, speech pathologist, nurse, and nutritionist. The need for a psychology evaluation is determined by intake information; the psychology evaluation is billed separately.

Swallowing disorder assessment, extended: This includes, at a minimum, a comprehensive evaluation by the occupational therapist and extended evaluations by the speech pathologist, nurse, and nutritionist. The need for a psychology evaluation is determined by intake information; the psychology evaluation is billed separately.

Swallowing disorder assessment, brief: The brief assessment includes approximately two hours of time for the occupational therapist, speech pathologist, and nutritionist.

Follow-up visit, brief: This includes a visit with two or more team members.

Follow-up visit, extended: This includes a visit which involves four or more team members.

The team's services are billed under the physician's provider number on Form CMS-1500 or the standard electronic Health Care Claim: Professional Transaction (ASC C12N 837). Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

The physician services are billed under appropriate CPT codes.

18-004.51 Comprehensive Interdisciplinary Treatment for a Severe Feeding Disorder: Comprehensive interdisciplinary treatment means the collaboration of medicine, psychology, nutrition science, speech therapy, occupational therapy, social work, and other appropriate medical and behavioral disciplines in an integrated program. Nebraska Medicaid may cover comprehensive interdisciplinary treatment for an infant or child with a severe feeding disorder that impacts the infant's or child's ability to consume sufficient nutrition orally to maintain adequate growth or weight.

18-004.51A Prior Authorization: Prior authorization is required of all services before the services are provided.

The requesting physician shall submit a request to the Department using the standard electronic Health Care Services Review Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transaction Instructions at 471-000-50) or by mail or fax to the following address:

Medical Director
Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
P.O. Box 95026
Lincoln, NE 68509-5026
Fax telephone number: (402) 471-9092

The request must include the following information or explanation as appropriate to the case:

1. A referral from the primary care physician that includes current appropriate medical evaluations or treatment plans;
2. Medical records for the last year that include height and weight measurements; and
3. Any records from feeding and swallowing clinic evaluations and other therapeutic interventions that have occurred.

18-004.51B Service Definitions: Nebraska Medicaid defines the services as follows:

Day treatment is defined as daily therapy (M-F) from approximately 8:30 am to 5 pm.

Outpatient is defined as therapy 1 to 2 times per week for 1-3 hours per day.

18-004.51C Billing: Claims for the following services must be submitted by using the paper Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837)

18-004.51D Payment Rates

18-004.51D1 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 scheduled amounts for covered services provided by Medicaid enrolled licensed practitioners.

18-004.51D2 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 for covered services provided by Medicaid enrolled licensed practitioners

18-004.52 Tobacco Cessation: Medicaid covers tobacco cessation services as practitioner and pharmacy services under the following conditions:

1. Up to two tobacco cessation sessions may be covered in a 12-month period. A session is defined as medical encounters and drug products as listed in items 2 and 3 below. Client access to the Nebraska Tobacco Free Quitline will be unlimited.
2. Practitioner Office Visits:
   a. Clients must see their medical care provider (physician/mid-level practitioner) for evaluation particularly for any contraindications for drug products and to obtain prescription(s) if tobacco cessation products are needed.
   b. (1) In addition to the evaluation under item 2a, a total of four tobacco cessation counseling visits with a medical care provider or tobacco cessation counselor (see 471 NAC 16-002.04) are covered for each tobacco cessation session. . This may be a combination of intermediate or intensive tobacco cessation counseling visits.
   (2) Tobacco cessation counseling provided by a Tobacco Cessation counselor must be ordered by the physician/mid-level practitioner.
3. Tobacco cessation products are covered by Medicaid as a pharmacy service (see 471 NAC 16-000) for those clients 18 years of age or older who require that particular assistance.
   a. Coverage of products used for tobacco cessation is limited to a maximum 90 days supply in one tobacco cessation session. The coverage period is limited to 90 consecutive calendar days, beginning with the date the first prescription for the products is dispensed.
   b. Tobacco cessation products will only be covered when clients are currently enrolled with and actively participating in the Nebraska Tobacco Free Quitline. Disenrollment or lack of active participation in the Nebraska Tobacco Free Quitline will result in discontinuation of Medicaid coverage of drug products.
4. Nebraska Tobacco Free Quitline: For coverage of tobacco cessation products, clients must be enrolled in and active with the Nebraska Tobacco Free Quitline. Referral to the Quitline may be made by a medical professional (physician/mid-level practitioner) or a self referral.

18-005 (Reserved)

18-006 Payment for Physician Services: Nebraska 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).

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.

18-006.02 Supplemental Payments: Supplemental payments will be made for services provided by practitioners who are acting in the capacity of an employee or contractor of the University of Nebraska Medical Center or its affiliated medical practices; UNMC Physicians and Nebraska Pediatric Practice, Inc. These payments are made in addition to payments otherwise provided under the state plan to practitioners that qualify for such payments. The supplemental payment applies to services provided by the following practitioners:

- Physicians (MD and DO)
- Advanced Nurse Practitioners
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Audiologists
- Optometrists
- Licensed Independent Mental Health Practitioners
- Psychologists

All services eligible for supplemental payments are billed under the federal employer number for the public entity.

For practitioners qualifying under this section, a supplemental payment will be made. The payment amount will be the difference between payments otherwise made to these practitioners and the average rate paid for the services by commercial insurers. The payment amounts are determined by:

1. Annually calculating an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the provider's contracted rates with the commercial insurers for each procedure code from an actual year's data, utilizing the rate in effect in January for payments during the calendar year.
2. Multiplying the total number of Medicaid claims paid per procedure by the average commercial payment rate for each procedure to establish the estimated commercial payments made for these services.
3. Subtracting the initial fee-for-service Medicaid payments and all Third Party Liability payments already made for these services to establish the supplemental payment amount. All claims where Medicare is the primary payor will be excluded from the supplemental payment methodology.
4. Calculating the supplemental payments 90 days after the end of each fiscal year quarter. For each fiscal quarter, the public entity will provide a listing of the identification numbers for their practitioner/practitioner groups that are eligible for the supplemental payment to the Department. The Department will generate a report, which includes the identification numbers and utilization data for the affected practitioners/practitioner groups. The amount due is paid to the University of Nebraska Medical Center. In no instance is the sum of the base payment and supplemental payment greater than the practitioner's initial charge for services rendered.

5. Paying initial fee-for-service payments made under this section on a claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents the final payment, will be made in four (4) quarterly payments.

With the exception of administrative costs incurred by the single state agency that are associated with calculating and implementing the adjustments, the entire benefit from the supplemental payments will be retained by the University of Nebraska Medical Center as an offset to incurred public expenditures.

18-007 Billing Requirements: Providers must bill NMAP on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) for all services including HEALTHCHECK (EPSDT) exams, and EPSDT-associated services.

Physicians' services must be billed on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837); physicians' services must not be billed by a hospital on the hospital claim form (Form CMS-1450 (UB-04) or electronic format).

The physician or the physician's authorized agent must approve and date each paper claim. Approval of paper claims is indicated by the handwritten signature, signature stamp, or computer-generated signature of the physician or authorized agent.

When a computer-encoded document or electronic transaction is used, the Department may request the provider's source input documentation from the provider for input verification and signature requirements.

The physician or the physician's authorized agent must enter the physician's usual and customary charge for each procedure code on the claim.

18-007.01 Procedure Codes: Physicians must 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:

1. Level 1: The codes contained in the most recently published edition of the American Medical Association's Current Procedural Terminology (CPT); and
2. Level 2: Federally-defined alpha-numeric codes.

18-008 PHYSICIAN SERVICES FOR PATIENT-CENTERED MEDICAL HOME PILOT: This is a time-limited pilot as defined in Neb. Rev. Stat Sections 68-957 to 68-961. Participation is limited to the practices selected by the Department.

18-008.01 Definition of Patient-Centered Medical Home: Patient-Centered Medical Home means a health care delivery model in which a patient establishes an ongoing relationship with a physician in a physician-directed team. This team will provide comprehensive, accessible, and continuous evidence-based primary and preventive care, and coordinate the patient's health care needs across the health care system in order to improve quality, safety, access, and health outcomes in a cost effective manner.

Practices for participation in the pilot will be limited to General Practice, Internal Medicine, Family Practice, and Pediatrics.

18-008.01A Service Components: The medical home is comprised of the following components:

1. Care coordination: One or more Medical Home staff are dedicated to coordinating the care of the patients. Care is coordinated across all facets of the health care system. Information technology is utilized to support patient care.
2. Accessibility: The medical home offers access to care outside traditional business hours and utilizes systems of care for access to the team 24 hours/day, 7 days/week.
3. Patient Engagement: Patients are encouraged to take responsibility for their health care through a clear health plan, joint decision making, and patient education provided by the medical home.
4. Quality Improvement: Members of the medical home team assume responsibility for continuous quality improvement through the use of data and evidence-based best practices.

18-008.02 Provider Participation: Practices selected by the Department to participate in the Medical Home Pilot shall meet the standards listed in the medical home agreement.

18-008.03 Payment

18-008.03A Fee-for-Service (FFS): The Medical Home provider will be reimbursed for all allowable Medicaid services. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule as described in 471 NAC 18-006.

18-008.03B Incentive Payment: The Medical Home provider will receive a per member per month and may receive an enhanced fee-for-service when certain standards are met.

18-008.03B1 Per Member Per Month (PMPM) Payment: For patient care coordination and administration expenses, the pilot Medical Home will receive an initial PMPM payment. This payment will begin once the agreement is signed; then the Medical Home must achieve minimum standards within six months. Once the minimum standards are met, the PMPM payment will be increased.

If the minimum standards are not met within six months, the PMPM payment will be suspended until the minimum standards have been met.

18-008.03B1a Client Attribution Method: The client will not be selecting a provider nor will s/he be assigned a provider by the Department. The determination of client assignment for the PMPM will be done through an attribution methodology that recognizes the client's choice of a provider as follows:

1. There will be a look-back at paid claims for the past 12 months for the Medical Home for selected Evaluation and Management and Preventive Visit codes for New and Established Patients.

2. If the client is currently Medicaid eligible, the Medical Home with the most visits with a specific client will receive the attribution and the PMPM payment and enhanced FFS (if applicable) for that client for the month. If there is a tie between pilot Medical Homes, the client will be attributed to the practice that provided care for the last/most recent visit in the 12-month period.

3. The attribution will be re-assessed on a monthly basis for a rolling twelve months (i.e. each month, the oldest month will be dropped and the newest month added).

4. PMPM payment will be paid retrospectively (example: on December 31st based on claims history, Medical Home A will receive an attribution of X number of clients and will be paid for that number of clients in January).

18-008.03B2 Enhanced Fee-for-Services (EFFS) Payment: Upon successful completion of minimum standards, the pilot Medical Home will have the option of continuing to transform the Medical Home to meet the advanced standards. Once the advanced standards are met, the Medical Home will receive an additional enhanced FFS payment on selected Evaluation and Management and Preventive Visit codes for Established Patients.

18-008.04 Billing: The allowable Medicaid services are billed under the Medical Home provider number on Form CMS-1500 or the standard electronic Health Care Claim: Professional Transaction (ASC C12N 837). The physician services are billed under appropriate CPT codes.

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

18-008.04A Billing for Medical Home Pilot Per-Member-Per-Month (PMPM) and for Enhanced Fee-for-Services (EFFS): The PMPM and EFFS will be automatically processed by the Department. The Medical Home does not need to submit a separate claim for either.