NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

February 1, 2022
1:00 p.m. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska
Phone call information: 888-820-1398; Participant code: 3213662#

The purpose of this hearing is to receive comments on proposed changes to Title 471, Chapter 18 of the Nebraska Administrative Code (NAC) – *Physicians' Services.* The proposed changes specify the regulations' scope; set out definitions; remove duplicate statutory, unnecessary, or inconsistent language from the regulations; establish requirements for the prescription drug monitoring program; remove directions to agency staff; update terminology; correct punctuation and grammar; update formatting; and restructure the regulatory chapter.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

In order to encourage participation in this public hearing, a phone conference line will be set up for any member of the public to call in and provide oral comments. Interested persons may provide verbal comments in person or by participating via phone conference line by calling 888-820-1398; Participant code: 3213662#.

Interested persons may attend the hearing and provide verbal or written comments, or mail, fax or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals who are deaf or hard of hearing may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

TO: Executive Board
Room 2108 State Capitol
Legislative Council

FROM: Marge Respeliers, Paralegal I
Legal Services
Department of Health and Human Services (DHHS)

DATE: December 21, 2021

RE: Notice of Rulemaking under Neb. Rev. Stat. § 84-907.06

The Department of Health and Human Services (DHHS) will be holding a public hearing on amending the following regulations:

TITLE:	471	Nebraska Medical Assistance Program
CHAPTER:	18	Physicians' Services

These regulations are scheduled for public hearing on February 1, 2022.

The purpose of this hearing is to receive comments on proposed changes to Title 471, Chapter 18 of the Nebraska Administrative Code (NAC) – *Physicians' Services.* The proposed changes specify the regulations' scope; set out definitions; remove duplicate statutory, unnecessary, or inconsistent language from the regulations; establish requirements for the prescription drug monitoring program; remove directions to agency staff; update terminology; correct punctuation and grammar; update formatting; and restructure the regulatory chapter.

The following items are enclosed for your referral to the chair of the relevant standing committee of the Legislature:

1. A copy of the notice of public hearing;
2. A copy of the proposed regulations;
3. A copy of the Policy Pre-Review Checklist; and
4. The estimated fiscal impact of this rulemaking action on state agencies, political subdivisions or persons being regulated.

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title:471	Prepared by: Erin Noble
Chapter: 18	Date prepared: 8-17-21
Subject: Physicians' Services	Telephone: 531-530-7154

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 18~~-000~~ PHYSICIANS' SERVICES

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute §§ 68-901 et seq.

002. DEFINITIONS. The following definitions apply:

002.01 COMPREHENSIVE INTERDISCIPLINARY TREATMENT. The collaboration of medicine, psychology, nutrition science, speech therapy, occupational therapy, social work, and other appropriate medical and behavioral disciplines in an integrated program.

002.02 CONSULTING PHYSICIAN. A physician whose services include history taking, examination of the individual, and, in each case, furnishing to the attending physician an opinion regarding diagnosis or treatment. A physician providing clinical laboratory services for individuals of other physicians is not considered a consulting physician.

002.03 EMERGENCY MEDICAL CONDITION. A medical behavior or condition, the onset of which is sudden, manifesting itself by symptoms of sufficient severity such that the absence of immediate medical attention could result in:

(A) Placing the health of the individual or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
(B) Serious impairment to such person's bodily functions; or
(C) Serious dysfunction of any bodily organ or part.

002.04 FEEDING AND SWALLOWING CLINIC. A specialized facility which provides assessment, treatment, ongoing support, and follow-up care for infants and children experiencing feeding difficulties.

002.05 INDEPENDENT CLINICAL LABORATORY. A laboratory which is independent both of an attending or consulting physician's office and of a hospital.

002.06 LABORATORY SERVICES. Microbiological, serological, chemical, hematological, radio bioassay, cytological, immunohematological, or pathological examinations or procedures performed on materials derived from the individual to provide information for the diagnosis or treatment of a disease, or an assessment of the medical condition of the individual.

002.07 PHYSICIAN CLINIC SERVICES. The professional activity, any drugs and supplies used during that professional encounter, and any other billable service provided in the physician clinic area.

002.08 PREGNANT WOMAN'S EMERGENCY MEDICAL CONDITION. With respect to a pregnant woman who is having contractions, an emergency medical condition exists when:

(A) There is inadequate time to safely transfer the woman to another hospital before delivery; or

(B) Transfer to another hospital may pose a threat to the health or safety of the woman or the unborn child.

002.09 RADIOLOGY SERVICES. 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 an individual.

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. To participate in Nebraska Medicaid, providers of physician services must comply with all applicable provider participation requirements codified in 471 Nebraska Administrative Code (NAC) 2 and 3. In the event provider participation requirements in 471 NAC 2 or 3 conflict with requirements outlined in this 471 NAC 18, the individual provider participation requirements in 471 NAC 18 will govern.

~~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.~~

003.02 SPECIFIC PROVIDER REQUIREMENTS.

~~18-001.02 Independent Clinical Laboratories:~~ 003.02(A) INDEPENDENT CLINICAL LABORATORIES. An independent clinical laboratory must have a separate provider agreement with the Department. In addition to the provider agreement, independent clinical laboratories must meet the following requirements:

(i~~1.~~)When state or applicable local law requires licensing of independent clinical laboratories, the laboratory must be licensed under the law; and

(ii~~2.~~)The laboratory must meet the health or safety requirements of the United States Secretary of ~~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.~~

003.02(B) PROVIDERS OF PORTABLE X-RAY SERVICES. To be approved as a Nebraska Medicaid provider, providers of portable x-ray services must be certified by the Centers for Medicare and Medicaid Services (CMS) Regional Office. Each provider must submit to the Department a copy of Form CMS-1539, Medicare and Medicaid Certification and Transmittal, and remain in compliance with 42 CFR 486.100 through 486.110. An out-of-state portable x-ray provider must provide the Department with verification of certification from the Centers for Medicare and Medicaid Services (CMS) Regional Office. The Department approves or denies enrollment as a Nebraska Medicaid provider based on the certification information received from the Centers for Medicare and Medicaid Services (CMS) Regional Office.

003.02(B)(i) APPLICABILITY OF HEALTH AND SAFETY STANDARDS. Providers of portable x-ray services, except physicians who provide immediate personal supervision during the administration of diagnostic x-ray services, must comply with all health and safety standards in NAC Title 180.

003.02(C) PROVIDERS OF NURSE MIDWIFE SERVICES. The nurse midwife is approved for enrollment in Medicaid under a group provider agreement with the physician with whom they have a practice agreement.

003.02(D) PROVIDERS OF NURSE PRACTITIONER SERVICES. A nurse practitioner may provide services within the specialty areas in which they hold certification. They must be enrolled in accordance with the Provider Agreement.

003.02(E) FEEDING AND SWALLOWING CLINIC. Along with the completed form MC-19: Medical Assistance Provider Agreement, the provider must submit a program overview which demonstrates the following components of service are available within the program:

(i) Interdisciplinary team evaluation which provides information to team members on the individual's medical status and nutrition and 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 such as attending or referring physician, nursing home, school;

(ii) Assessment by the occupational therapist of the individual’s tone and posture to determine seating and positioning for feeding and for the video fluoroscopy procedure;

(iii) Examination by the speech pathologist to assess the individual’s oral structures and clinical swallowing evaluation;

(iv) A video fluoroscopy swallow study to determine conditions which are most favorable for a safe, efficient swallow and management of feeding problems;

(v) Assessment of oral motor function and feeding behaviors. Depending on the needs of the individual, 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 individual to provide additional information used to establish therapeutic intervention;

(vi) Conference by team members to review finding, establish priorities, and coordinate treatment and follow-up recommendations; and

(vii) Presentation of plan of care to the individual or 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 individual's care.

004. SERVICE REQUIREMENTS.

004.01 MEDICAL NECESSITY. The definition of medical necessity from 471 NAC 1 is incorporated as if fully rewritten herein. Services and supplies which do not meet the 471 NAC 1 definition of medical necessity are not covered. Physicians' services may be provided at the physician's office, the individual's home, a hospital, a long term care facility, or elsewhere. Additionally, Nebraska Medicaid covers medically necessary physicians' services within program guidelines which are provided:

(A) Within the scope of the practice of medicine or osteopathy as defined by Nebraska state law; and

(B) By, or under the personal supervision of, an individual licensed under Nebraska state law to practice medicine or osteopathy.

004.02 PRIOR AUTHORIZATION. For services provided to individuals enrolled in a managed care program, physicians must follow prior authorization guidelines of the applicable managed care plan. For all other individuals, physicians must request prior authorization from the Department before providing:

(1) Medical transplants;
(2) Abortions;
(3) Cosmetic and reconstructive surgery;
(4) Bariatric surgery for obesity;
(5) Out-of-state services, except emergency services provided out-of-state;
(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; or
(10) Ventricular assist device.

004.02(A) PRIOR AUTHORIZATION PROCEDURES. Prior to providing the service, a request for prior authorization must be submitted by the physician using the standard electronic Health Care Services Review – Request for Review and Response transaction, Form ASC X12N 278.

004.02(A)(i) REQUEST FOR ADDITIONAL EVALUATIONS. The Department may request, and the provider must submit, additional evaluations when the Department determines the medical history for the request is questionable or when there is not sufficient information to support the requirements for authorization.

004.02(A)(ii) NOTIFICATION PROCESS. Upon determination of approval or denial, the Department provides a written notification, as applicable, to the physician submitting the request, the caseworker, and the medical review organization.

004.02(A)(iii) VERBAL AUTHORIZATION PROCEDURES. The Department may issue a verbal authorization when circumstances are of an emergency nature or urgent to the extent a delay would place the individual at risk of not receiving medical care. When a verbal authorization is granted, the standard electronic Health Care Services Review – Request for Review and Response transaction form must be submitted within 14 calendar days of the verbal authorization.

004.02(A)(iv) BILLING AND PAYMENT REQUIREMENTS. Claims submitted to the Department for services requiring prior authorization will not be paid without written or electronic approval. 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.

004.02(B) PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS. The Department requires 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. Physicians wishing to prescribe these drugs must obtain prior authorization by submitting the request to either the Nebraska Point of Sale contractor or the Nebraska Medicaid pharmacy unit or its designee. The Department or the Nebraska Point of Sale contractor will respond to requests for prior authorization within 24 hours of receipt of the request. In cases of medical emergency, Nebraska Point of Sale contractor or the Department will authorize dispensing a 72 hour supply of a covered outpatient prescribed medication as described in 471 NAC 16.

004.02(C) PRODUCTS REQUIRING PRIOR APPROVAL. Identifiable products requiring approval prior to payment are designated as such on the Nebraska Point of Sale System or on the Department's website. The following prescribed products require prior approval:

(i) Sunscreen;
(ii) Certain modified versions, combinations, double-strength entities, or products considered by the Department to be equivalent to drug products contained on the state maximum allowable cost or federal upper limit listings in 471 NAC 16;
(iii) Human growth hormone;
(iv) Erythropoietin;
(v) Drugs or supplies intended for convenience use;
(vi) Drugs used for prevention of infection with respiratory syncytial virus;
(vii) Certain drugs or classes of drugs used for gastrointestinal disorders, including but not limited to hyperacidity, gastroesophageal reflux disease, ulcers, or dyspepsia;
(viii) Certain drugs or classes of drugs used for relief of pain, discomfort associated with musculoskeletal conditions, inflammation or fever;
(ix) Certain drugs or classes of drugs used for relief of cough or symptoms of the common cold, influenza or allergic conditions;
(x) Certain drugs or classes of drugs used for both non-covered services or indications and for covered services or indications;

(xi) Certain drugs or classes of drugs on the state maximum allowable cost or federal upper limit listings;
(xii) Certain drugs or classes of drugs upon initial availability or marketing or when Nebraska Medicaid coverage begins;
(xiii) Certain drugs or classes of drugs used for tobacco cessation; and
(xiv) Certain drugs or classes of drugs determined by the Pharmaceutical and Therapeutics Committee to not be placed onto the Preferred Drug List.

004.02(D) PRIOR AUTHORIZATION FOR PHYSICIAN ADMINISTERED DRUGS. The following drugs administered in the clinical setting require prior authorization:
(i) Any drug used for the prevention of respiratory syncytial virus infections;
(ii) Certain drugs used for the treatment of multiple sclerosis;
(iii) Enzyme replacement therapy (ERT) or lysomal storage disorders;
(iv) Immunoglobulin E (IgE) blocker therapies for asthma;
(v) Certain drugs or classes of drugs upon initial availability or marketing or when Nebraska Medicaid coverage begins; and
(vi) Drugs not covered under the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

004.02(E) PRIOR AUTHORIZATION FOR BARIATRIC SURGERY. Prior authorization requests must include, but are not limited to, documentation of:
(i) Medical diagnosis;
(ii) Body mass index (BMI) 35 or greater with one of the following co-morbidities:
(1) Diabetes mellitus, including recent laboratory results and current medications;
(2) Hypertension, including current medications, antihypertensive and blood pressure readings;
(3) Coronary artery disease (CAD), congestive heart failure (CHF), dyslipidemia, including recent laboratory results and current medications;
(4) Obstructive sleep apnea, including sleep study results and treatment;
(5) Gastroesophageal reflux disease (GERD), including test results and current medications being used to manage the symptoms;
(6) Osteoarthritis, including information about the individual's ability to ambulate, assistive devices used, and any medications being used to manage symptoms;
(7) Pseudotumor cerebri, including diagnostic reports, imaging; and
(8) Cardiac and pulmonary evaluations and, if existing, cardio-pulmonary co-morbidities and all related consults;
(iii) Dietary consultation, including documentation showing completion of a supervised diet program for six months or more, and a determination the individual is motivated to comply with dietary changes;
(iv) Psychiatry or Psychology consultation which includes:
(1) Evaluation to determine readiness for surgery and lifestyle change; and
(2) No behavior health disorder by history and physical exam;
(a) Exam includes no severe psychosis or personality disorder; and
(b) Mood or anxiety disorder excluded treatment. If treated, include treatment medications and modalities;
(v) Drug or alcohol screen;

(1) No drugs or alcohol by history, or alcohol and drug free for a period of at least one year; and

(2) No history of smoking, or smoking cessation has been attempted; and

(vi) individual's understanding of surgical risk, post procedure compliance and follow-up.

004.02(F) PRIOR AUTHORIZATION FOR TRANSPLANT SERVICES. Nebraska Medicaid requires prior authorization of all transplant services. Physicians must request and receive prior authorization before performing any transplant service or related donor service. The request for authorization must include, at a minimum:

(i) The individual's name, Medicaid identification number, and date of birth;

(ii) Diagnosis, pertinent past medical history and treatment, prognosis with and without the transplant, and the procedures for which the authorization is requested;

(iii) Name of the hospital, city, and state where the services will be performed, including the National Provider Identifier (NPI) of the provider;

(1) All providers must be enrolled with Nebraska Medicaid before services are performed. Out-of-state services are covered in accordance with 471 NAC 1;

(iv) Name of the physician who will perform the surgery if other than the physician requesting authorization;

(v) In addition to the above information, a physician specializing in the specific transplantation must also supply the following:

(1) The screening criteria used in determining an individual is an appropriate candidate for a liver, heart, allogenic, intestinal, or multi-visceral transplant;

(2) The results of the screening for the individual; and

(3) A written statement by the physician:

(a) Recommending the transplant;

(b) Certifying and explaining why the transplant is medically necessary as the only clinical, practical, and viable alternative to prolong the individual's life in a meaningful, qualitative way and at a reasonable level of functioning; and

(c) Including a psycho-social evaluation for solid organ transplants; and

(vi) For heart, lung, liver, stem cell, bone marrow, allogeneic, or intestinal or multi-visceral transplants, a second physician specializing in the specified transplant must also supply the above required information.

004.02(G) PRIOR AUTHORIZATION FOR NEW OR UNUSUAL SURGICAL PROCEDURES. A provider must request and receive prior authorization from the Department for all new or unusual surgical procedures. The provider must submit a copy of the notification of authorization only when instructed to do so in the text of the authorization.

004.02(H) PRIOR AUTHORIZATION FOR COSMETIC AND RECONSTRUCTIVE SURGERY. In addition to the prior authorization requirements included in this chapter, the surgeon who will be performing the cosmetic or reconstructive surgery must submit a request to the Department. This request must include the following:

(i) An overview of the medical condition and medical history of any conditions caused or aggravated by the condition;

(ii) Photographs of the involved area when appropriate to the request;
(iii) A description of the procedure being requested, including any plan to perform the procedure when it requires a staged process; and
(iv) When appropriate, additional information regarding the medical history may be submitted by the individual's primary care physician.

004.02(I) PRIOR AUTHORIZATION OF RADIOLOGY PROCEDURES. Nebraska Medicaid does not require prior authorization for individuals enrolled in fee-for-service needing radiology procedures. For members covered by a managed care organization, refer to the plan for prior authorization procedures.

004.02(J) PRIOR AUTHORIZATION FOR COMPREHENSIVE INTERDISCIPLINARY TREATMENT FOR A SEVERE FEEDING DISORDER. Prior authorization is required for all services before the services are provided. The requesting physician must submit a request to the Department including the following information or explanation as appropriate to the case:
(i) A referral from the primary care physician which includes current appropriate medical evaluations or treatment plans;
(ii) Medical records for the last year which include height and weight measurements; and
(iii) Any records from feeding and swallowing clinic evaluations and other therapeutic interventions which have occurred.

004.03 DEFINITIONS AND TERMS OF COMMONALITY. The Current Procedural Terminology (CPT) contains terms and phrases common to the practice of medicine. Claims for physicians' services must be coded according to the definitions in the Current Procedural Terminology (CPT). At the request of the Department, the provider must submit copies of individual's medical records to document the level of care provided. If the requested documentation is not provided or is insufficient in contents, payment may be withheld or recouped. The Department recognizes the definitions and reporting requirements of the Current Procedural Terminology (CPT), but coverage of Nebraska Medicaid services is based on the regulations in NAC Title 471.

~~18-002 Covered Services:~~ 005. 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:~~ 005.01 FACILITY-BASED PHYSICIAN CLINICS. Physician ~~C~~clinic services provided in a hospital location or a facility under the hospital's licensure are considered ~~content of the~~ to be a physician service, not an outpatient hospital service~~s~~. ~~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.~~(A)~~Nebraska Medicaid~~ The Department does not recognize facility~~/~~ or 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.~~(B)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.~~(i)Of the type commonly furnished in a physician's office;

~~b.~~(ii)Furnished as an incidental, although integral, part of the physician professional service; and

~~c.~~(iii)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).~~

005.02 HOSPITAL ADMISSION DIAGNOSTIC PROCEDURES. In addition to the previously defined medical necessity requirements, the Department will consider the following to determine whether a diagnostic procedure performed as part of the admitting procedure to a hospital is reasonable and medically necessary:

(A) The test is specifically ordered by the admitting physician, or a hospital staff physician responsible for the individual when there is no admitting physician;

(B) The test is medically necessary for the diagnosis or treatment of the individual's condition; and

(C) The test does not unnecessarily duplicate:

(i) The same test performed on an outpatient basis before admission; or

(ii) The same test performed in connection with a separate, but recent, hospital admission.

005.03 MINOR SURGICAL PROCEDURES. Reimbursement for excision of lesions of the skin or subcutaneous tissues include all services and supplies necessary to provide the service. The Department 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, the Department may approve separate payment for the suture removal.

005.04 TREATMENT FOR OBESITY. The Department will not make payment for services provided when the sole diagnosis is obesity. While obesity is not itself considered an illness, there are conditions which can be caused by or aggravated by obesity. Treatment for obesity may be covered when the services are an integral and necessary part of a course of treatment or treatment for covered co-morbidities.

005.04(A) INTESTINAL BYPASS SURGERY. Nebraska Medicaid does not cover intestinal bypass surgery

005.04(B) BARIATRIC SURGERY FOR OBESITY. This procedure must be performed at a Bariatric Surgery Center of Excellence. Bariatric surgery for individuals with severe obesity may be covered when the surgery is medically appropriate for the individual and

is performed to correct an illness which either causes the obesity or was aggravated by obesity.

005.05 COSMETIC AND RECONSTRUCTIVE SURGERY. Nebraska Medicaid covers cosmetic and reconstructive surgical procedures and medical services, when medically necessary, for the purpose of correcting the following conditions:

(1) Limitations in movement of a body part caused by trauma or congenital conditions;
(2) Disfiguring or painful scars in areas which are visible;
(3) Congenital birth anomalies;
(4) Post-mastectomy breast reconstruction; and
(5) Other procedures determined to be restorative or necessary to correct a medical condition.

005.05(A) EXCEPTIONS. To determine the medical necessity of the condition, the Department requires prior authorization for cosmetic and reconstructive surgical procedures except for the following conditions:

(i) Cleft lip and cleft palate;
(ii) Post-mastectomy breast reconstruction;
(iii) Congenital hemangiomas of the face; and
(iv) Nevus removals.

005.06 STERILIZATIONS.

005.06(A) COVERAGE RESTRICTIONS. Nebraska Medicaid does not cover sterilization of individuals:

(i) Under the age of 21 on the date the individual signs Form MMS-100: Sterilization Consent Form; or
(ii) Who are mentally incompetent or institutionalized.

005.06(B) COVERAGE CONDITIONS. Nebraska Medicaid covers sterilizations only when:

(i) The sterilization is performed because the individual receiving the service made a voluntary request for services;
(ii) The individual is advised at the outset and before the request or receipt of their 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;
(iii) Individuals whose primary language is other than English are provided with the required elements for informed consent in their primary language; and
(iv) Suitable arrangements are made to communicate the required elements of informed consent to an individual who is blind, deaf, or otherwise handicapped.

005.06(C) PROCEDURE FOR OBTAINING SERVICES. Non-therapeutic sterilizations are covered by Nebraska Medicaid only when:

(i) Legally effective informed consent is obtained on Form MMS-100: Sterilization Consent Form from the individual on whom the sterilization is to be performed. The surgeon must submit a completed form to the Department before payment of claims can be considered; and

(ii) The sterilization is performed at least 30 days following the date informed consent was given. To calculate this time period, day 1 is the first day following the date on which the form is signed by the individual. Day 31 in this period is the first day on which the procedure may be covered. The consent is effective for 180 days from the individual's signature.

005.06(D) EXCEPTION. 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 the individual signed the informed consent for the sterilization. For a premature delivery, the individual 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: Sterilization Consent Form

005.06(E) INFORMED CONSENT. Informed consent means the voluntary, knowing assent of the individual who is to be sterilized after they have been given the following information and completed Form MMS-100: Sterilization Consent Form:

(i) A clear explanation of the procedures to be followed;
(ii) A full description of the discomforts and risks which may follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
(iii) A description of the benefits to be expected;
(iv) 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;
(v) An offer to answer any questions concerning the procedures;
(vi) An instruction that the individual is free to withhold or withdraw consent to the sterilization at any time before the sterilization without prejudicing future care and without loss of other project or program benefits to which the individual might otherwise be entitled;
(vii) Advice that the sterilization will not be performed for at least 30 days, except under the circumstances previously specified; and
(viii) The individual to be sterilized must be permitted to have a witness of his or her choice present when informed consent was obtained.

005.06(F) STERILIZATION CONSENT FORMS. The surgeon will submit a completed Form MMS-100: Sterilization Consent Form to the Department before payment of claims can be considered. The Sterilization Consent Form must be signed and dated by the individual to be sterilized, the person obtaining consent, the physician who will perform the procedure, and the interpreter if one was provided.

005.07 HYSTERECTOMIES. Nebraska Medicaid covers a medically necessary hysterectomy if the following conditions have been met and a completed form is submitted to the Department by the surgeon before claims for the hysterectomy can be considered for payment:

(1) The individual who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing; and

(2) The individual or her representative, if any, has signed Form MMS-101: Informed Consent for Hysterectomy, acknowledging receipt of the above information.

005.07(A) EXCEPTION. Informed consent is not required in the following situations. A copy of the surgeon's certification of the following exceptions must be submitted to the Department prior to consideration of payment for claims associated with the hysterectomy:

(i) The individual was sterile before the hysterectomy, and the physician performing the hysterectomy certifies in writing that the individual was sterile before the hysterectomy and states the cause of the sterility;

(ii) Nebraska Medicaid considers post-menopausal women to be sterile. All claims related to the procedure must indicate the individual is post-menopausal; or

(iii) The individual requires a hysterectomy due to a life-threatening emergency situation and the physician determines informed consent is not possible. The physician performing the hysterectomy must certify, in writing, that the hysterectomy was performed under a life-threatening emergency situation in which informed consent was not possible. The physician must also include a certification of the emergency.

005.07(B) NON-COVERED HYSTERCTOMIES. Nebraska Medicaid does not cover a hysterectomy if it was performed solely to make the woman sterile or, if there was more than one purpose for the procedure, it would not have been performed except to make the woman sterile.

005.08 INFERTILITY. Nebraska Medicaid limits coverage for infertility to diagnosis and treatment of medical conditions when infertility is a symptom of a suspected medical condition. Reimbursement or coverage is not available when the sole purpose of the service is achieving a pregnancy.

005.09 ALCOHOL AND CHEMICAL DETOXIFICATION. Nebraska Medicaid limits alcohol and chemical detoxification to medically necessary treatment, subject to the Department's utilization review.

005.10 OSTEOGENIC STIMULATION. Electrical stimulation to augment bone repair, also known as osteogenic stimulation, can be performed either invasively or noninvasively.

005.10(A) INVASIVE OSTEOGENIC STIMULATION. Nebraska Medicaid covers use of the invasive device only for non-union of long bone fractures. Nebraska Medicaid considers non-union to exist only after six months or more have elapsed without the fracture healing.

005.10(B) NON-INVASIVE OSTEOGENIC STIMULATION. Nebraska Medicaid covers the use of the non-invasive device only for non-union of long bone fractures, failed fusion, or congenital psuedoathroses.

005.11 BIOFEEDBACK THERAPY. Nebraska Medicaid covers biofeedback therapy only when it is reasonable and necessary for the individual 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 have not been successful.

This therapy is not covered for treatment of ordinary muscle tension states, for psychosomatic conditions, or for psychiatric conditions.

005.12 SLEEP DISORDER CLINICS. Sleep disorder clinics are facilities in which certain conditions are diagnosed through the study of sleep. Nebraska Medicaid covers diagnostic and therapeutic services of a sleep disorder clinic under the following conditions.

005.12(A) DIAGNOSTIC SERVICES. Diagnostic testing which is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered. Individuals who undergo diagnostic testing are not considered inpatients; however, if required as part of the diagnostic testing, the overnight stay is considered an integral part of these tests. All reasonable and necessary diagnostic tests given for narcolepsy and sleep apnea are covered when the following criteria are met:

(i) The clinic must be affiliated with a hospital;
(ii) The individual must be referred to the sleep disorder clinic by a physician. The clinic must maintain a record of the attending physician's orders; and
(iii) The need for diagnostic testing must be confirmed by medical evidence, such as physician examinations and laboratory tests.

005.12(B) THERAPEUTIC SERVICES. Nebraska Medicaid may cover therapeutic services provided they are standard and accepted services, and are reasonable and medically necessary for the individual. Sleep disorder clinics must provide therapeutic services in the hospital outpatient setting. Therapeutic services may be provided for:

(i) Insomnia which is not associated with psychiatric disorders;
(ii) Nocturnal myoclonus, also known as muscle jerks;
(iii) Sleep apnea;
(iv) Drug dependency;
(v) Shift work and schedule disturbances;
(vi) Restless leg syndrome;
(vii) Hypersomnia, also known as excessive daytime sleepiness;
(viii) Somnambulism;
(ix) Night terrors or dream anxiety attacks;
(x) Enuresis; and
(xi) Bruxism.

005.13 SURGERY. Nebraska Medicaid covers surgical procedures, including 14 days of post-operative care. When multiple procedures are performed at the same time, the primary procedure and any secondary procedures are covered and reimbursed in accordance with this chapter. Incidental procedures through the same incision are not considered separate secondary procedures for reimbursement.

005.13(A) ASSISTANT SURGEON. Nebraska Medicaid covers the services of an assistant surgeon when reasonable and medically necessary.

005.13(B) NEW OR UNUSUAL SURGICAL PROCEDURES. Nebraska Medicaid may cover new or unusual surgical procedures. In all cases, the Department will determine the necessity or usefulness of the procedure pursuant to a prior authorization request.

005.13(C) SECOND SURGICAL OPINION. Nebraska Medicaid provides coverage for individuals who desire a second physician's opinion concerning proposed surgery.

005.13(D) SERVICES PERFORMED IN AN AMBULATORY SURGICAL CENTER. In addition to the federally-identified ambulatory surgical center services, Nebraska Medicaid covers the certain state-defined services provided in an ambulatory surgical center. Payment for facility services provided in connection with the state-defined procedures will not exceed payment for the corresponding group of Medicare-covered ambulatory surgical center procedures. Federally-identified ambulatory surgical center services are defined in 471 NAC 26.

005.14 HOSPITAL VISITS. Nebraska Medicaid covers only one visit per day by the same physician, or physicians of the same specialty from the same group practice, unless the primary physician states on Form CMS-1500: Health Insurance Claim Form, or electronically, more than one visit was necessary because of serious illness or change in condition, and approval is given by the Department.

005.14(A) SURVEILLANCE AND UTILIZATION REVIEW CRITERIA. The Department may contract with a medical review organization to review inpatient hospital services. The physician must 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.

005.15 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 individual is evaluated or treated for an emergency medical condition. The facility must review emergency room services and determine whether services provided in the emergency room constitute an emergency and bill accordingly;
(2) If the individual’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 individual is referred by his or her physician for treatment in an emergency room.

005.15(A) NON-EMERGENT SERVICES. 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 what would otherwise be allowed. When these conditions are met, the physician's fee will be disallowed to the rate of a comparable office service. All other Nebraska Medicaid allowable charges incurred in this type of visit will be paid according to 471 NAC 10

005.16 PRENATAL, DELIVERY, AND POSTPARTUM CARE. Nebraska 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 laboratory and medical services which are not related to the pregnancy, or which are not included as part of the package service. Postpartum services are covered for a 60-day period beginning on the day of delivery, and any remaining

days in the month in which the 60th day falls, for women who were eligible for, applied for, and received medical assistance on the day the pregnancy ends. After the infant is delivered, the infant is treated as a separate patient for reimbursement purposes.

005.16(A) NURSE MIDWIFE SERVICES. Nebraska Medicaid covers nurse midwife services which are medically necessary and provided in accordance with the practice as defined by law. Nebraska Medicaid 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. Nebraska Medicaid 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 separately.

005.17 ANTIGENS. Nebraska Medicaid may make payment for a reasonable supply of antigens which have been prepared for and administered to a particular individual even though the antigens have not been administered to the individual by the same physician who prepared them if:

(A) The antigens are prepared by a physician who is a doctor of medicine or osteopathy; and

(B) The physician who prepared the antigens has examined the individual and determined a plan of treatment and a dosage regimen.

005.18 DIALYSIS. Nebraska Medicaid follows Medicare’s guidelines for coverage of dialysis.

005.19 FAMILY PLANNING SERVICES. Nebraska Medicaid covers family planning services, including consultation and procedures, provided upon the request of the individual. The individual 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 must be and furnished, directed, or supervised by a physician or registered nurse. Family planning services must:

(A) Be provided without regard to age, sex or marital status. There can be no discrimination in the provision of services and information; and

(B) The scope of available services and information must include medical, social and educational services and information, including 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.

005.20 FRACTURE CARE. Coverage of initial fracture care includes the application and removal of the first cast or traction device.

005.21 DRUGS.

005.21(A) COVERED DRUGS. Nebraska Medicaid covers outpatient prescription drugs in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (Public Law 101-508) including legend drugs, compounded prescriptions, and over-the-counter (OTC) drugs indicated as covered on the Nebraska Point of Sale System or listed on the Department’s website.

005.21(A)(i) PREFERRED DRUG LIST (PDL). Nebraska Medicaid will include on the preferred drug list prescribed drugs which 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 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.

005.21(A)(ii) COMPOUNDED PRESCRIPTIONS. Any mixture of drugs which results in a commercially available over-the-counter (OTC) preparation is not considered a compounded prescription.

005.21(A)(iii) OVER-THE-COUNTER (OTC) DRUGS. Nebraska Medicaid covers only over-the-counter (OTC) drugs indicated as covered on the Nebraska Point of Sale System or listed on the Department's website. Over-the-counter (OTC) drugs must be prescribed by a licensed practitioner.

005.21(B) 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 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: Physician's Certification Form that a brand name is medically necessary.

005.21(C) INJECTIONS. In addition to the limitations in 471 NAC 16, injections 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 or clinic.

005.22 PRACTITIONER-ADMINISTERED MEDICATIONS. Practitioner administered injectable medications will be reimbursed at average sales prices (ASP) plus 6%, consistent with the Medicare Drug Fee Schedule. Injectable medications not available on the Medicare Drug Fee Schedule will be reimbursed at whole acquisition cost (WAC) plus 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 will be reimbursed at the 340B actual acquisition cost and no more than the 340B ceiling price. 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 which 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 this chapter.

005.22(A) ALLERGY INJECTIONS. See payment limitations in this chapter.

005.22(B) VITAMIN 8-12 INJECTIONS. Nebraska Medicaid covers vitamin B-12 injections as specific or effective treatment for:

(i) Gastrectomy;
(ii) Idiopathic steatorrhea;
(iii) Ileostomy;
(iv) Internal cancers;
(v) Macrocytic anemia;
(vi) Megaloblastic anemia;
(vii) During or after radiation therapy;
(viii) Certain neuropathies;
(ix) Pernicious anemia; and
(x) Post-surgical and mechanical disorders.

005.23 CHEMOTHERAPY. Nebraska Medicaid covers chemotherapy which has been provided and billed in accordance with this chapter.

005.24 IMMUNIZATIONS. Routine immunizations are available to Nebraska Medicaid covered children and adolescents from birth through age 20 under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Vaccines for those individuals age 18 and younger are available through the Vaccine for Children (VFC) program. The Department will not reimburse for a physician's private stock vaccine when the vaccine is available through the Vaccine for Children (VFC) program. Immunizations for adults age 21 and older are covered by the Department on a case by case basis when medically necessary.

005.25 LABORATORY SERVICES. Laboratory services may be provided in a physician's or group of physicians' private office, in a licensed and certified independent clinical laboratory, or in a hospital whose certification covers services performed in the laboratory.

005.25(A) PHYSICIAN'S OFFICE LABORATORY. A laboratory which a physician or a group of physicians maintains for performing diagnostic tests in connection with their own or the group practice is not considered an independent clinical laboratory.

005.25(B) LICENSED AND CERTIFIED INDEPENDENT CLINICAL LABORATORIES. 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. 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. Nebraska Medicaid may cover laboratory

tests which have been referred by one independent laboratory to another. Nebraska Medicaid does not cover handling services for tests referred to a second laboratory. A specimen collection fee is not covered for samples where the cost of collecting the specimen is minimal, such as a throat culture, a routine capillary puncture, or a pap smear.

005.26 RADIOLOGY SERVICES. Claims for radiology procedures must have at least a provisional diagnosis or statement of symptoms. The Department will not accept claims with a diagnosis of 'routine radiology'. These services may be provided in a physician's or group of physicians' private office or a hospital whose certification covers the radiological services provided.

005.26(A) PHYSICIAN'S PRIVATE OFFICE. Nebraska Medicaid covers the total radiology procedure when both the technical and professional components of medically necessary radiological procedures are performed in a physician's private office.

005.26(B) HOSPITAL RADIOLOGY SERVICES. When a physician orders medically necessary radiological services performed in a hospital, Nebraska Medicaid covers those services under 471 NAC 10. The Department does not reimburse the private physician for interpreting radiology procedures performed outside their office.

005.26(C) MAMMOGRAMS. Nebraska Medicaid covers mammograms when provided based on a medically necessary diagnosis. In the absence of a diagnosis, Nebraska Medicaid covers mammograms provided according to the American Cancer Society's periodicity schedule.

005.26(D) ULTRASOUND DIAGNOSTIC PROCEDURES. Nebraska Medicaid covers ultrasound diagnostic procedures listed by Medicare under Category I. The Department may review claims for these procedures to ensure the techniques are medically appropriate and the general indications of Medicare's categories are met. Claims for uses other than those listed under Medicare's Category I will be reviewed before payment. Nebraska Medicaid does not cover ultrasound procedures listed by Medicare under Category II.

005.26(E) COMPUTERIZED TOMOGRAPHY (CT) SCANS. Nebraska Medicaid covers diagnostic examinations of the head and of certain other parts of the body performed by computerized tomograhy (CT) scanners when medical and scientific literature and opinion support the use of a scan for the condition, the scan is reasonable and necessary for the individual, and the scan is performed on a model of computerized tomograhy (CT) equipment which meets Medicare's criteria for coverage.

005.26(E)(i) REASONABLE AND NECESSARY. To be determined reasonable and necessary for the individual, the use of the computerized tomograhy (CT) scan must be medically appropriate considering the individual's symptoms and preliminary diagnosis. The Department may determine the use of a computerized tomograhy (CT) scan as the initial diagnostic test was not reasonable and necessary because it was not supported by the individual's symptoms and complaints stated on the claim form or electronic format. The Department reviews claims for computerized tomograhy (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.

005.26(F) PORTABLE X-RAY SERVICES. Nebraska Medicaid covers diagnostic x-ray services provided by a certified portable x-ray provider when provided in a place of residence used as the individual'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 must be met. Nebraska Medicaid also covers diagnostic portable x-ray services when provided in participating skilled nursing facilities (SNF) under circumstances in which they cannot be covered as skilled nursing facility (SNF) services, such as those services not provided by the participating institution either directly or under arrangements which allow the institution to bill for the services. If portable x-ray services are provided in a participating hospital under arrangement, the hospital will bill for the service.

005.26(F)(i) COVERED PORTABLE X-RAY SERVICES. Nebraska Medicaid covers the following portable x-ray services:

(1) Skeletal films involving arms, legs, pelvis, vertebral column, and skull;
(2) Chest films which do not involve the use of contrast media and are not used for routine screening or physical examinations; and
(3) Abdominal films which do not involve the use of contrast media.

005.26(F)(ii) ELECTROCARDIOGRAMS. The taking of an electrocardiogram tracing by an approved provider of portable x-ray services may be covered as an 'other diagnostic test'.

005.27 HOSPITAL 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. Nebraska Medicaid may designate other services as having professional and technical components when the services are identified.

005.27(A) 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. 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.

005.27(A)(i) COVERAGE CONDITIONS. To be covered as a professional component, the physician's services must:

(1) Be personally provided to an individual by a physician;
(2) Contribute directly to the diagnosis or treatment of an individual;
(3) Ordinarily require performance by a physician;
(4) Be medically necessary; and

(5) For anesthesiology, laboratory, or radiology services, meet the requirements previously set forth in this chapter.

005.27(B) TECHNICAL COMPONENT. The technical component of hospital diagnostic and therapeutic services is covered in accordance with 471 NAC 10.

005.27(C) PRE-ADMISSION TESTING. Nebraska Medicaid does not cover pre-admission testing performed in a physician's office which is performed solely to satisfy hospital pre-admission requirements.

005.27(D) RADIOLOGY AND PATHOLOGY. Nebraska Medicaid covers medically necessary radiological and pathological services provided to inpatients and outpatients. Nebraska Medicaid covers only those services which are directly related to the individual's diagnosis.

005.27(D)(i) OUTPATIENT DIAGNOSTIC SERVICES PROVIDED BY ARRANGEMENT. Nebraska Medicaid covers medically necessary diagnostic services provided to an outpatient by arrangement.

005.27(D)(ii) LABORATORY AND PATHOLOGY.

005.27(D)(ii)(1) PROFESSIONAL COMPONENT. Nebraska Medicaid covers as a physician's service the professional component of laboratory services provided by a physician to an individual only if the services meet the conditions of coverage previously outlined and are:

(a) Anatomical pathology services; or
(b) Consultative pathology services, which must:
(i) Be requested by the individual's attending physician;
(ii) Relate to a test result which lies outside the clinically significant normal or expected range in view of the individual's condition;
(iii) Result in a written narrative report included in the individual's medical record; and
(iv) Require the exercise of medical judgment by the consulting physician; or
(v) Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual.

005.27(D)(ii)(2) TECHNICAL COMPONENT. Clinical laboratory services do not require performance by a physician and are considered the technical component. There is no professional component for these services.

005.27(D)(ii)(3) 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.

005.27(D)(ii)(4) CLINICAL LABORATORY CONSULTATION. Nebraska Medicaid covers a physician clinical laboratory consultation if the service:

(a) Is requested by the individual's attending physician;
(b) Relates to a test result which lies outside the clinically significant normal or expected range for the individual's condition;
(c) Results in a written narrative report which is included in the individual's record; and
(d) Requires the exercise of medical judgement by the consulting physician.

005.27(D)(iii) RADIOLOGY. All radiology services have a technical component and a professional component. The professional and technical component of hospital services must be separately identified for billing and payment.

005.27(D)(iii)(1) PROFESSIONAL COMPONENT. The professional component of radiology services provided by a physician to an individual is covered as a physician's service when the services meet the previously outlined conditions of coverage and the services are identifiable, direct, and discrete diagnostic or therapeutic services to an individual, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures.

005.27(D)(iii)(2) TECHNICAL COMPONENT. The technical component of hospital diagnostic and therapeutic services is covered in accordance with 471 NAC 10.

005.28 NON-PHYSICIAN CARE PROVIDERS. Nebraska Medicaid covers services provided by non-physician care providers who have fulfilled all state and federal licensing, certification and training requirements, under the following conditions:

(A) 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, or graduate physician assistant who has completed a committee on allied health education and accreditation (CAHEA) accredited surgical residency program;
(B) The service provided by the non-physician care provider must be within the scope of practice as defined by state law; and
(C) The non-physician care provider must provide the services under a practice agreement between the non-physician care provider and their 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 they provide the services.

005.29 PHYSICIAN SERVICES IN SKILLED NURSING FACILITIES (SNF), INTERMEDIATE CARE FACILITIES (ICF) AND INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). The physician must complete, sign and date Form DM-5: Physician's Confidential Report prior to admission in a skilled nursing facility (SNF), intermediate care facility (ICF) or intermediate care facility for individuals with developmental disabilities (ICF/DD). Form DM-5: Physician's Confidential Report serves as the certification required by federal regulations. If the admission is a facility-to-facility transfer, local office staff will obtain a copy of the individual's annual history and physical, if it is current to the individual's condition within 30 days before the transfer, and attach it to the signed and dated Form DM-5: Physician's Confidential Reports. The physician

must examine the individual before completing the certification, within the following time frames:

(1) SKILLED NURSING FACILITIES (SNF). The individual must have a physical examination no later than two business days after admission unless an examination was performed within five days before admission; and

(2) INTERMEDIATE CARE FACILITIES (ICF). The individual must have a recent physical examination within 30 days before admission or the date eligibility was determined, or no later than two business days after admission or the date eligibility was determined.

005.29(A) ANNUAL PHYSICAL EXAMINATION. Nebraska Medicaid requires all long term care facility residents have an annual physical examination. The physician, based on their authority to prescribe continued treatment, determines the extent of the examination for individuals based on medical necessity. Nebraska Medicaid does not cover routine laboratory and radiology services which are not directly related to the individual's diagnosis and treatment; however, for the annual physical exam, a complete blood count (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 resident. The results of the examination must be recorded in the individual's medical record.

005.29(B) PHYSICIANS' SERVICES FOR SKILLED NURSING FACILITY (SNF) RESIDENTS.

005.29(B)(i) PHYSICIANS' VISITS. The physician must see the skilled nursing facility (SNF) resident 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 individual's medical record, the individual's condition does not require visits at 30-day intervals. The facility's Utilization Review Committee will approve the alternate schedule. At the time of each visit, the physician must document the visit in the individual's medical record, and write and sign a progress note on the individual's condition.

005.29(B)(ii) REVIEW OF PLAN OF CARE. The physician and facility staff involved in the (SNF) resident's care will review each plan of care every 60 days. This should be done in conjunction with a physician's visit or recertification.

005.29(B)(iii) RECERTIFICATION. For skilled nursing facility (SNF) residents, the physician or the physician's assistant will recertify in writing the individual's continued need for the current level of care every 30 days for the first 90 days, every 60 days thereafter, and at any time the individual requires a different level of care. The physician's assistant or nurse practitioner may recertify the individual'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 must sign, or stamp and initial, the recertification clearly identifying themselves. The recertification must also be dated at the time it is signed. Facility staff

must maintain the recertification in the individual's medical record in the facility or building where the individual resides.

005.29(B)(iii)(1) ON-SITE RECERTIFICATION. The physician must record recertification accomplished by on-site visits to the facility in the individual's record.

005.29(C) PHYSICIANS' SERVICES FOR RESIDENTS OF INTERMEDIATE CARE FACILITIES (ICF'S) AND INTERMEDIATE CARE FACILITIES FOR THE DEVELOPMENTALLY DISABLED (ICF/DD'S).

005.29(C)(i) PHYSICIAN'S VISITS. The physician must see the intermediate care facility (ICF) resident whenever necessary, but at least once every 60 days, unless the physician determines 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 individual to claim the service. At the time of each visit, the physician must document the visit in the individual's medical record, and write and sign a progress note on the individual's condition.

005.29(C)(ii) REVIEW PLAN OF CARE. The interdisciplinary team, which includes the physician, must review each intermediate care facility (ICF) plan of care every 90 days. This should be done in conjunction with recertification and is not reimbursed separately.

005.29(C)(iii) RECERTIFICATION. The physician must recertify in writing the individual's continued need for the intermediate care facilitites for the developmentally disabled (ICF/DD) level of care at least once every 365 days, and at any time the individual requires a different level of care. The extended recertification period in no way indicates one year is the appropriate length of stay for an individual in an intermediate care facilitites for the developmentally disabled (ICF/DD). The interagency team responsible for the individual's care determines the individual's length of stay. The physician's assistant or nurse practitioner may recertify the individual'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 must sign, or stamp and initial, the recertification clearly identifying themselves. The physician, physician's assistant, or nurse practitioner must date the recertification at the same time it is signed. Facility staff must maintain the recertification in the individual's medical record in the facility or building where the individual resides.

005.29(C)(iii)(1) ON-SITE RECERTIFICATION. The physician must record recertification accomplished by on-site visits to the facility in the individual's record.

005.30 TELEPHONE CONSULTATIONS. Nebraska Medicaid does not cover telephone calls to or from an individual, pharmacy, nursing home, or hospital. Nebraska Medicaid may cover telephone consultations with another physician if the name of the consulting physician is indicated on or in the claim.

005.31 MEDICAL TRANSPLANTS. Nebraska Medicaid covers transplants, including donor services which are medically necessary and defined as non-experimental by Medicare. Nebraska Medicaid may cover transplantation services when performed in a facility approved by Centers for Medicaid and Medicare (CMS) as meeting coverage criteria. Nebraska Medicaid is the payor of last resort, see 471 NAC 3. Nebraska Medicaid requires prior authorization of all transplant services before the services are provided. An exception may be made for emergency situations, in which case verbal approval is obtained and the notification of authorization is sent later.

005.31(A) SERVICES FOR A MEDICAID-ELIGIBLE DONOR. Nebraska Medicaid covers medically necessary services, including laboratory tests directly related to the transplant, for the Nebraska Medicaid-eligible donor to a Nebraska Medicaid-eligible individual. The services must be directly related to the transplant.

005.31(B) SERVICES FOR A MEDICAID-INELIGIBLE DONOR. Nebraska Medicaid covers medically necessary services, including laboratory tests directly related to the transplant, for a Nebraska Medicaid-ineligible donor to a Nebraska Medicaid-eligible individual. The services must be directly related to the transplant and must directly benefit the Nebraska Medicaid transplant recipient. Coverage of treatment for complications related to the donor is limited to those which are reasonably medically foreseeable.

005.31(C) AMBULATORY ROOM AND BOARD. Nebraska Medicaid may cover ambulatory room and board services for transplant patients for the individual and an attendant, if necessary.

005.32 ITINERANT PHYSICIAN VISITS. Nebraska Medicaid covers non-emergency physician visits provided in a hospital outpatient setting if the services are:

(A) Provided by an out-of-town specialist who has a contractual agreement with the hospital. Medicaid does not consider general practitioners or family practitioners to be specialists; and

(B) Determined to have been provided in the most appropriate place of service in accordance with 471 NAC 2.

005.33 NURSE PRACTITIONER SERVICES. Nebraska Medicaid covers nurse practitioner services, in accordance with the scope of practice applicable to their specific licensure designation.

005.34 DURABLE MEDICAL EQUIPMENT AND SUPPLIES. With certain exceptions, Nebraska Medicaid does not enroll hospitals, hospital pharmacies, long term care facilities, rehabilitation services or centers, or physicians as providers of durable medical equipment and medical supplies.

005.34(A) INFANT APNEA MONITORS. Nebraska Medicaid covers rental of home infant apnea monitors for infants with medical conditions which 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 or caregiver training must occur before placement of infant apnea monitor. In addition to the regulations outlined herein, apnea monitoring services must be provided in accordance with 471 NAC 7.

005.34(A)(i) DOCUMENTATION REQUIRED AFTER INITIAL RENTAL PERIOD. Monitor rental exceeding the original two-month prescription period requires an updated physician's narrative report of patient progress and a statement of continued need to 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.

005.34(A)(ii) PNEUMOCARDIOGRAMS. Pneumocardiograms are covered only when physician ordered to determine when the infant may be removed from the monitor. Payment for rental of an electrocardiogram (ECG) respirator recorder includes all accessories required to obtain a valid pneumocardiogram. Coverage of durable medical equipment does not include analysis and interpretation of tests, which is covered for the physician performing the service.

005.34(B) HOME PHOTOTHERAPY. Nebraska Medicaid 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. In addition to the regulations outlined herein, home phototherapy services must be provided in accordance with 471 NAC 7.

005.34(B)(i) LIMITATIONS ON COVERAGE OF HOME PHOTOTHERAPY SERVICES. Coverage of the rental of home phototherapy equipment does not include physician's professional services or laboratory and radiology services related to home phototherapy.

005.34(C) AMBULATORY UTERINE MONITORS. Nebraska Medicaid 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. In addition to the regulations outlined herein, ambulatory uterine monitor services must be provided in accordance with 471 NAC 7.

005.34(C)(i) LIMITATIONS ON COVERAGE OF AMBULATORY UTERINE MONITORS. Nebraska Medicaid covers 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 individual is at home and appropriately using the monitor.

005.35 ANESTHESIOLOGY.

005.35(A) PROFESSIONAL COMPONENT. Nebraska Medicaid covers, as a physician's service, the professional component of anesthesiology services provided by a physician to an individual if the conditions in this chapter are met.

005.35(B) 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), is covered as a physician's service when the services meet the requirements previously designated as conditions of coverage and the following additional requirements:

(1) For each individual, 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 any procedures in the anesthesia plan that he or she 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.

005.35(B)(i) 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 which do not constitute a separate service for determining medical direction:

(a) Addressing an emergency of short duration in the immediate area;
(b) Administering an epidural or caudal anesthetic to ease labor pain;
(c) Periodic, rather than continuous, monitoring of an obstetrical patient;
(d) Receiving patients entering the operating suite for the next surgery;
(e) Checking or discharging patients in the recovery room; and
(f) Handling scheduling matters.

005.35(B)(i)(1) SERVICES CONSIDERED A TECHNICAL COMPONENT. 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.

005.35(C) 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 concurrent procedures, the concurrent anesthesia services are covered as the technical component of the hospital services. The physician must 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.

005.35(D) STANDBY ANESTHESIA SERVICES. A physician's standby anesthesia services are covered when the physician is physically present in the operating suite, monitoring the individual's condition, making medical judgments regarding the individual's anesthesia needs, and is ready to furnish anesthesia services to a specific individual who is known to be in potential need of services.

005.35(E) SERVICES OF CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA). When anesthesia services are provided by an anesthesiologist and a certified registered nurse anesthetist (CRNA) at the same time, Nebraska Medicaid will cover only those services provided by the anesthesiologist. In the event multiple surgical procedures are performed at the same time, Nebraska Medicaid only covers the certified registered nurse anesthetist (CRNA) services for the major procedure. Nebraska Medicaid does not cover certified registered nurse anesthetist (CRNA) services for secondary procedures.

005.36 FEEDING AND SWALLOWING CLINIC SERVICES. This service is covered for those individuals with dysphagia, a medical condition which makes feeding and swallowing difficult. The service is covered when the individual is referred by a physician for a medical evaluation. The purpose of the evaluation is to assess the individual's current status and potential for improvement and to develop a plan of care for the individual.

005.36(A) DEFINITIONS. For the purposes of feeding and swallowing clinic services, the following definitions will apply:

005.36(A)(i) 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; if necessary, the psychology evaluation is billed separately.

005.36(A)(ii) 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; if necessary, the psychology evaluation is billed separately.

005.36(A)(iii) SWALLOWING DISORDER ASSESSMENT, BRIEF. The brief assessment includes approximately two hours of time for the occupational therapist, speech pathologist, and nutritionist.

005.36(A)(iv) FOLLOW-UP VISIT, BRIEF. This includes a visit with two or more team members.

005.36(A)(v) FOLLOW-UP VISIT, EXTENDED. This includes a visit which involves four or more team members.

005.36(B) INITIAL EVALUATION. An initial evaluation must be performed by an interdisciplinary team (IDT), which, at a minimum, must include a nurse, occupational therapist, speech pathologist, nutritionist, psychologist, and radiologist. The

interdisciplinary team (IDT) must be under the direction of a physician. After the initial visit, the interdisciplinary team (IDT) formulates a formal written report and sends copies to the individual or family, the referring physician, and others designated by the individual or family and by the Department. The team contacts the referring physician and, if appropriate, other medical professionals, to provide immediate feedback to the team on primary findings and recommendations.

005.36(C) FOLLOW-UP VISITS. Follow-up visits must be available in a frequency adequate to meet patient needs and program objectives.

005.36(D) FOLLOW-UP CALLS. Follow-up telephone calls are made after the initial evaluation and are included in the cost of the evaluation, as follows:

(i) Within 48 hours after the evaluation, a team member calls the individual or family to answer questions and provide clarification, if needed, for any information presented during the initial visit;

(ii) Two to four weeks after the initial visit, a follow-up call is made to ask about progress and problems in following the plan of care; and

(iii) Ongoing telephone communication is maintained with the individual or family and referring physician to facilitate implementation of the plan of care.

005.37 COMPREHENSIVE INTERDISCIPLINARY TREATMENT FOR A SEVERE FEEDING DISORDER. Nebraska Medicaid covers comprehensive interdisciplinary treatment for an infant or child with a severe feeding disorder when it impacts the infant's or child's ability to consume sufficient oral nutrition to maintain adequate growth or weight.

005.37(A) DEFINITIONS. For the purposes of comprehensive interdisciplinary treatment for a severe feeding disorder services, the following definitions will apply:

005.37(A)(i) DAY TREATMENT. Daily therapy, which occurs Monday through Friday, from approximately 8:30 am to 5 pm.

005.37(A)(ii) OUTPATIENT. Therapy one to two times per week for one to three hours per day.

005.38 TOBACCO CESSATION. Nebraska Medicaid covers tobacco cessation services as practitioner and pharmacy services, for individuals 18 years of age or older, under the following conditions:

(A) Tobacco cessation services must be ordered by a physician or mid-level practitioner, and provided in accordance with the provider requirements listed in 471 NAC 16;

(B) 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 below. Individual access to the Nebraska Tobacco Free Quitline will be unlimited;

(C) Practitioner office visits:

(i) Individuals must see their medical care provider for evaluation particularly for any contraindications for drug products and to obtain prescriptions if tobacco cessation products are needed;

(ii) In addition to the evaluation, a total of four tobacco cessation counseling visits with a medical care provider or tobacco cessation counselor are covered for each

tobacco cessation session. This may be a combination of intermediate or intensive tobacco cessation counseling visits;

(D) Tobacco cessation products are covered by Nebraska Medicaid as a pharmacy service for those 18 years of age or older who require this particular assistance;

(i) 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;

(ii) Tobacco cessation products will only be covered when individuals 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 Nebraska Medicaid coverage of tobacco cessation drug products; and

(E) Nebraska Tobacco Free Quitline: Referral to the Quitline may be made by a medical professional or a self-referral.

005.39 ENDOMETRIAL ASPIRATION. Nebraska Medicaid covers vacutage type or other endometrial aspiration or curettage. The provider must submit the pathologist's report on the tissue with all claims for this service. For diagnoses of absent, delayed, or late menstruation, the physician must administer a pregnancy test to verify the individual is not pregnant. When requested, the provider must submit copies of individuals' medical records to the Department.

005.40 MEDICAL NUTRITION THERAPY FOR INDIVIDUALS AGE 21 AND OLDER. Medical nutrition therapy is available to individuals with medical needs which require nutritional assessment, intervention, and continued monitoring. Nebraska Medicaid covers one-on-one medical nutrition therapy provided by a licensed medical nutritional therapist for individuals age 21 and older under the following guidelines:

(A) The service is covered when the individual is referred by a physician or nurse practitioner. A nutritional assessment is done by an individual's primary care provider. The diagnostic finding from the exam must indicate a nutritional problem or condition of such severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.

(B) Individuals must meet at least one of the following medical conditions:

(i) Type I or Type II diabetes;

(ii) Current kidney disease; or

(iii) A kidney transplant in the last 36 months.

(C) Individuals receiving dialysis in a dialysis facility receive medical nutrition therapy as part of their overall dialysis care, medical nutrition therapy is not separately billable.

(D) Medical nutrition therapy includes the assessment, intervention, and counseling provided to prevent, improve, or resolve identified nutritional problems. Coverage of medical nutrition therapy allows for:

(i) Three hours in the first year;

(ii) Two hours in subsequent years; and

(iii) Additional hours are considered to be medically necessary and covered if the treating physician determines there is a change in medical condition, diagnosis, or treatment regimen which requires a change in medical nutrition therapy and orders additional hours during that episode of care. The Department may request periodic review of the services.

~~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~~ 006. NON-COVERED SERVICES. The services outlined in this section are specifically excluded from coverage by the Department. This is not intended to be an all-inclusive, or exhaustive, list of non-covered services

~~18-003.01~~ ~~Surgical Procedures:~~ 006.01 SURGICAL PROCEDURES. ~~NMAP~~ Nebraska Medicaid does not cover:~~-~~

~~1.~~(A)Acupuncture;
~~2.~~(B)Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography or multi-plane, supervision and interpretation in conjunction with cineradiography;
~~3.~~(C)Angiocardiography, utilizing CO_2 method, supervision and interpretation only;
~~4.~~(D)Angiography, coronary, unilateral selective injection supervision and interpretation only, single view unless emergency;
~~5.~~(E)Angiography, extremity, unilateral, supervision and interpretation only, single view unless emergency;
~~6.~~(F)Ballistocardiogram;
~~7.~~(G)Basal metabolic rate (BMR);
~~8.~~(H)Bronchoscopy, with injection of contrast medium for bronchography or with injection of radioactive substance;
~~9.~~(I)Circumcision, female;
~~10.~~(J)Excision of carotid body tumor, with or without excision of carotid artery, when used as a treatment for asthma;
~~11.~~(K)Extra-intra cranial arterial bypass for stroke;
~~12.~~(L)Fabric wrapping of abdominal aneurysm;
~~13.~~(M)Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain;
~~14.~~(N)Fascia lata by stripper when used as a treatment for lower back pain;
~~15.~~(O)Hypogastric or presacral neurectomy as an independent procedure;
~~16.~~(P)Hysterotomy, non-obstetrical, vaginal;
~~17.~~(Q)Icterus index;
~~18.~~(R)Ileal bypass or any other intestinal surgery for the treatment of obesity; ~~and~~
~~19.~~(S)Kidney decapsulation, unilateral and bilateral;
~~20.~~(T)Ligation of femoral vein, unilateral and bilateral, when used as treatment for post-phlebotic syndrome;
~~21.~~(S)Ligation of internal mammary arteries, unilateral or bilateral;
~~22.~~(U)Ligation of thyroid arteriesas an independent procedure;
~~23.~~(V)Nephropexy: fixation or suspension of kidney as an independent procedure, unilateral;
~~24.~~(W)Omentopexy for establishing collateral circulation in portal obstruction;
~~25.~~(X)Perirenal insufflation;

~~26.~~(Y)Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study;
~~27.~~(Z)Protein bound iodine (PBI);
~~28.~~(AA)Radical hemorrhoidectomy, whitehead type, including removal of entire pile bearing area;
(BB) Refractive keratoplasty, includes keratomileusis, keratophakia, and radial keratotomy;
~~29~~(CC)Reversal of tubal ligation or vasectomy;
~~30.~~(DD)Sex change procedures;
(FF)Solid organ transplants performed in a facility which is not included on the list of Medicare-approved transplant programs;
~~31.~~(GG)Splanchicectomy, unilateral or bilateral, when used as a treatment for hypertension;
~~32.~~(HH)Supracervical hysterectomy: subtotal hysterectomy, with or without tubes ~~and/~~or ovaries, one or both;
~~33.~~(II)Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as a treatment for hypertension; or
~~34.~~(JJ)Uterine suspension, with or without presacral sympathectomy.

~~18-003.02 Obsolete Tests:~~ 006.02 OBSOLETE TESTS. ~~NMAP does not routinely cover the following diagnostic tests because they are obsolete and have been replaced by more advanced procedures:~~ Unless determined to be medically necessary by the physician performing the test and verified by the Department, Nebraska Medicaid does not cover the following obsolete diagnostic tests:

~~1.~~(A)Amylase, blood isoenzymes, electrophoretic;
~~2.~~(B)Chromium, blood;
~~3.~~(C)Guanase, blood;
~~4.~~(D)Zinc sulphate turbidity, blood;
~~5.~~(E)Skin test, cat scratch fever;
~~6.~~(F)Skin test, lymphopathia venereum;
~~7.~~(G)Circulation time, one test;
~~8.~~(H)Cephalin flocculation;
~~9.~~(I)Congo red, blood;
~~10.~~(J)Hormones, adrenocorticotropin quantitative animal tests;
~~11.~~(K)Hormones, adrenocorticotropin quantitative bioassay;
~~12.~~(L)Thymol turbidity, blood;
~~13.~~(M)Skin test, actinomycosis;
~~14.~~(N)Skin test, brucellosis;
~~15.~~(O)Skin test, leptospirosis;
~~16.~~(P)Skin test, psittacosis;
~~17.~~(Q)Skin test, trichinosis;
~~18.~~(R)Calcium, feces, 24-hour quantitative;
~~19.~~(S)Starch; feces, screening;
~~20.~~(T)Chymotrypsin, duodenal contents;
~~21.~~(U)Gastric analysis pepsin;
~~22.~~(V)Gastric analysis, tubeless;
~~23.~~(W)Calcium saturation clotting time;
~~24.~~(X)Capillary fragility test;

~~25.~~(Y)Colloidal gold;
~~26.~~(Z)Bendien's test for cancer and tuberculosis;
~~27.~~(AA)Bolen's test for cancer; and
~~28.~~(BB)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:~~ 006.03 SERVICES REQUIRED TO TREAT COMPLICATIONS OR CONDITIONS RESULTING FROM NON-COVERED SERVICES. ~~NMAP~~ Nebraska Medicaid may consider ~~payment for~~ coverage of medically necessary services ~~that~~ which are required to treat complications or conditions resulting from non-covered services. If the services are determined to be part of a previous non-covered service, such as an extension or a periodic segment of a non-covered service or follow-up care associated with it, the subsequent services will be denied.

~~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:~~ 006.04 SERVICES NOT REASONABLE AND NECESSARY. ~~NMAP~~ Nebraska Medicaid 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:~~ 006.05 SURGICAL ASSISTANT FEES. ~~NMAP~~ Nebraska Medicaid does not cover surgical assistance fees for the following. Additional assistant fees may be determined to be noncovered during the utilization review process.

~~1.~~(A)Laparoscopy, including laparoscopic tubal ligation;
~~2.~~(B)Tonsillectomy, adenoidectomy, myringotomy;
~~3.~~(C)Conservative or closed fracture care; and
~~4.~~(D)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.~~

006.06 EXPERIMENTAL AND INVESTIGATIONAL SERVICES. Nebraska Medicaid does not cover medical services which are considered investigational or experimental or which are not generally employed by the medical profession. While the circumstances leading to participation in an experimental or investigational program may meet the definition of medical necessity, the Department prohibits payment for these services.

006.06(A) RELATED SERVICES. Nebraska Medicaid does not pay for associated or adjunctive services which are directly related to non-covered experimental or investigational services. The Department will pay for all medically necessary expenses incurred which are not directly related to the non-covered experimental or investigative services. Nebraska Medicaid may cover complications of non-covered services once the non-covered service is completed.

006.06(B) REQUESTS FOR MEDICAID COVERAGE. Requests for Nebraska Medicaid coverage for new services or those which may be considered experimental or investigational must be submitted in writing before providing the services, or in the case of medical emergencies, before submitting a claim. The request for coverage must include sufficient information to document the new service is not considered investigational or experimental for Department payment purposes. Reliable evidence must be submitted identifying the status on the new service with regard to the criteria listed below, cost-benefit data, short and long term outcome data, patient selection criteria which is both disease or condition specific and age specific, information outlining the circumstances under which the service is considered the accepted standard of care, and any other information which would be helpful to the Department in deciding coverage issues. Additional information may be requested by the Department. Requests must be submitted to the Department's Medical Director.

006.06(B)(i) INVESTIGATIONAL AND EXPERIMENTAL CRITERIA. Services may be deemed investigational or experimental by Nebraska Medicaid, which may convene ad hoc advisory groups of experts to review requests for coverage. A service is deemed investigational or experimental if it meets any one of the following criteria:

(1) The Food and Drug Administration (FDA), or other governmental or regulatory authority, has not approved the service or treatment for general marketing to the public for the proposed use;

(2) Reliable evidence does not lead to the conclusion that there is a consensus within the medical community that the service is a generally accepted standard

of care employed by the medical profession as a safe and effective service for treating or diagnosing the condition or illness for which its use is proposed. Reliable evidence includes peer reviewed literature with statistically significant data regarding the service for the specific disease or proposed use and age group. Also, facility specific data, including short and long term outcomes, must be submitted to the Department;

(3) The service is available only through an institutional review board (IRB) research protocol for the proposed use or subject to such an institutional review board (IRB) process; or

(4) The service is the subject of an ongoing clinical trial which meets the definition of a phase I, phase II, or phase III clinical trial, regardless of whether the trial is actually subject to Food and Drug Administration (FDA) oversight and regardless of whether an institutional review board (IRB) process or protocol is required at any one particular institution.

006.06(C) DEFINITION OF CLINICAL TRIALS. For services not subject to Food and Drug Administration (FDA) approval, the following definitions apply:

(i) PHASE I. Initial introduction of an investigational service into humans.

(ii) PHASE II. Controlled clinical studies conducted to evaluate the effectiveness of the service for a particular indication or medical condition of the individual; these studies are also designed to determine the short-term side effects and risks associated with the new service.

(iii) PHASE III. Clinical studies to further evaluate the effectiveness and safety of a service which is needed to evaluate the overall risk and benefit and to provide an adequate basis for determining patient selection criteria for the service as the recommended standard of care. These studies usually compare the new service to the current recommended standard of care.

~~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:~~ 006.07 NON-COVERED PORTABLE X-RAY SERVICES. ~~NMAP~~ Nebraska Medicaid does not cover the following portable x-ray services:

~~1.~~(A) Procedures involving fluoroscopy;

~~2.~~(B) Procedures involving the use of contrast media;

~~3.~~(C) Procedures requiring the administration of a substance to the ~~patient~~ individual or injection of a substance into the ~~patient~~ individual ~~and/~~ or special manipulation of the ~~patient~~ individual;

4.(D)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.(E)Procedures requiring special technical competency and/ or special equipment or materials;
6.(F)Routine screening procedures; and
7.(G)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:~~ 006.08 NON-COVERED DRUG SERVICES. Payment by ~~NMAP~~ Nebraska Medicaid 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.).~~

(A) Requests for quantities not in compliance with 471 NAC 16;

~~2.~~(B) Experimental drugs or non-Food and Drug Administration (FDA) approved drugs;

~~3.~~(C) Drugs or items when the prescribed use is not for a medically accepted indication;

~~4.~~(D) Drugs or items prescribed or recommended for weight control ~~and/~~ or appetite suppression;

~~5.~~(E) Liquors ~~(any alcoholic beverage)~~;

~~6.~~(F) Drug Efficacy Study Implementation Program (D~~.~~E~~.~~S~~.~~I~~.~~) drugs ~~(Drug Efficacy Study Implementation Program)~~ identified as less than effective (LTE) or ~~and all~~ identical,

related, or similar (IRS) ~~drugs~~ with an indicator value assigned by the Food and Drug Administration (FDA) of either five or six;

~~7.~~(G)Personal care items ~~(examples: non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, and contact solutions)~~;

~~8.~~(H)Medical supplies and certain drugs for nursing facility and intermediate care facility for ~~the~~ individuals with developmental disabilities (ICF/DD) residents, ~~mentally retarded (ICF/MR) patients~~ ~~(~~see 471 NAC 7~~-000~~ and 16~~-004.07)~~;

~~9.~~(I)Over-the-counter (OTC) drugs not listed on the Nebraska Point of Sale system or on the Department's web site;

~~10.~~(J)Drugs or items used for cosmetic purposes or hair growth;

~~11.~~(K)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.~~(L)Drugs distributed or manufactured by certain drug manufacturers or labelers ~~that~~ who have not agreed to participate in the drug rebate program;

~~13.~~(M)Products used to promote fertility;

~~14.~~(N)Medications dispensed as partial month fills for nursing facility or group home residents when dispensed by more than one pharmacy;

(O) Medications dispensed to replace products which have been recalled by the drug manufacturer;

~~15.~~(P)Drugs, items, or products of manufacturers~~/~~ or labelers ~~that~~ which are identifiable as non-covered on the ~~Ne-POP~~ Nebraska Point of Sale system or on the Department's website;

~~16.~~(Q)Drugs, classes of drugs, or therapeutic categories of drugs ~~that~~ which are Medicare Part D ~~D~~drugs and Medicare Part D ~~C~~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 ~~P~~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.~~(R)Drugs or classes of drugs approved by the ~~Federal~~ Food and Drug Administration (FDA) for treatment of sexual or erectile dysfunction, or drugs or classes of drugs ~~that~~ which are being used for the treatment of sexual or erectile dysfunction. Drugs or classes of drugs ~~that~~ which are approved by the ~~Federal~~ Food and Drug Administration (FDA) 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~~ Nebraska Medicaid may require prior authorization. ~~(~~See 471 NAC 16~~-004).~~; and

(S) Automatic Refills, see 471 NAC 16.

~~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 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.

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.~~

~~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:~~ 006.09 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, n~~No payment is made to a physician giving influenza injections in ~~these~~ long-term care facilities.

~~18-004.28D Injectable Estrogens:~~ 006.10 INJECTABLE ESTROGENS. ~~NMAP~~ Nebraska Medicaid does not pay for injectable estrogens for depression or osteoporosis associated with menopause.

~~18-004.28E Liver and Vitamin Injections:~~ 006.11 LIVER AND VITAMIN INJECTIONS. ~~The Department~~ Nebraska Medicaid does not pay for liver and vitamin injections.

006.12 AUTOPSIES. Autopsies are a non-covered service under Nebraska Medicaid.

007. BILLING FOR PHYSICIAN SERVICES.

007.01 GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event individual billing requirements in 471 NAC 3 conflict with billing requirements outlined in this chapter, the individual billing requirements in this chapter will govern.

007.02 SPECIFIC BILLING REQUIREMENTS. 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. 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.

007.02(A) PROCEDURE CODES. Physicians must use Healthcare Common Procedure Coding System (HCPCS) procedure codes when submitting claims to the Department for Medicaid services. Healthcare Common Procedure Coding System (HCPCS) and Current

Procedural Terminology (CPT) procedure codes used by the Department are listed in the Nebraska Medicaid Practitioner Fee Schedule.

007.02(B) PORTABLE X-RAY SERVICES. Claims for portable x-ray services must contain the name of the physician who ordered the service and a diagnosis of medical necessity.

007.02(C) SECOND SURGICAL OPINION. The second physician must bill Nebraska Medicaid with a Healthcare Common Procedure Coding System (HCPCS) consultation procedure code indicating the level of the consultation and identifying the service as a second surgical opinion.

007.02(D) PRENATAL, DELIVERY AND POSTPARTUM CARE. When billing Nebraska Medicaid for prenatal, delivery, and postpartum care, the provider must submit a claim at the time of delivery. When the primary physician does not participate in the total obstetrical care, the partial care may be billed separately from the delivery using the appropriate procedure codes. An explanation for the partial care must be submitted. Providers must use one procedure code but must provide individual dates of service on the claim. One charge is submitted covering all:

(i) Routine prenatal care, vaginal delivery, and postpartum care; or
(ii) Routine prenatal care, cesarean delivery, and postpartum care.

007.02(E) FRACTURE CARE. Providers may claim subsequent replacement of cast or traction devices used during or after the period of follow-up care as an independent service using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code.

007.02(F) PRACTITIONER ADMINISTERED MEDICATIONS. When billing for medications administered during the course of a clinic visit, the physician must use the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for the medication, the correct number of units per the Healthcare 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) number of units. A Current Procedural Terminology (CPT) code for the administration must also be submitted. When billing for medication which does not have a specific Level I or II code, the physician must use a miscellaneous Healthcare 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.

~~18-004.28F Chemotherapy:~~ 007.02(F)(i) CHEMOTHERAPY. Providers must bill for chemotherapy ~~on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49),~~ using Healthcare Common Procedure Coding System (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 Healthcare Common Procedure Coding System (HCPCS) procedure code, the number of units

per the Healthcare 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 of National Drug Code (NDC) units. For drugs ~~that~~ which do not have a specific Healthcare Common Procedure Coding System (HCPC~~s~~S) 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, and the National Drug Code (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.~~

007.02(F)(ii) IMMUNIZATIONS. When using Vaccine for Children (VFC) vaccines, only the administration is ~~to be~~ billed to ~~the Department~~ Nebraska Medicaid ~~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 Vaccine for Children (VFC) federally determined state maximum for Nebraska.

~~Contact the Nebraska VFC program with any questions regarding the state maximum.~~ It is not necessary to submit a National Drug Code (NDC) when billing for vaccines.

~~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.~~

007.02(G) PHYSICIAN'S OFFICE 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 Healthcare Common Procedure Coding System (HCPCS) procedure code.

007.02(H) LICENSED AND CERTIFIED INDEPENDENT CLINICAL LABORATORY. The physician must indicate on or with the appropriate claim form or electronic format the fee for obtaining the specimen by venipuncture or catheterization is for tests performed outside his or her office and submit the name of the facility performing the tests on the claim.

007.02(I) 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 as previously described 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. 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.

~~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).~~

007.02(J) ANESTHESIOLOGY. The professional component must be claimed and must indicate actual time in one-minute increments. The physician's medical direction of four or fewer concurrent anesthesia procedures is considered a professional component.

007.02(J)(i) STANDBY ANESTHESIA. The professional component must be billed appropriately.

~~18-004.33D5~~ ~~Claims for Payment:~~ 007.02(J)(ii) CLAIMS FOR PAYMENT. When a physician bills for anesthesia services, the physician ~~shall~~ must certify with the claim, as appropriate, that:~~–~~

(1~~.~~)The services were personally provided by the physician to the individual; or

(2~~.~~)When the physician provided medical direction for certified registered nurse anesthetist (CRNA) services, the number of concurrent services directed is indicated by the appropriate modifier.

007.02(J)(iii) STERILIZATION OR HYSTERECTOMY. 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 completed copy of Form MMS-101: Informed Consent for Hysterectomy, signed and dated by the individual 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. Claims for these services must indicate actual time in one-minute increments.

007.02(J)(iv) CLAIMS FOR CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) SERVICES. Claims for certified registered nurse anesthetist (CRNA) services must be billed accordingly, except rural hospitals which have been exempted by their Medicare fiscal intermediary for certified registered nurse anesthetist (CRNA) billing must follow the Medicare billing requirements. The Department does not make additional reimbursement for emergency and risk factors. When multiple surgical procedures are performed at the same time, the certified registered nurse anesthetist (CRNA) must bill only for the major procedure. Medicaid does not make payment for certified registered nurse anesthetist (CRNA) services for secondary procedures.

~~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.~~

007.02(K) LABORATORY AND PATHOLOGY.

~~18-004.33E4 Billing and Payment for Inpatient Hospital Anatomical Pathology Services:~~ 007.02(K)(i) INPATIENT HOSPITAL ANATOMICAL PATHOLOGY

SERVICES. Payment for the ~~technical component~~ technical component of anatomical pathology is included in the hospital's payment~~.~~ in accordance with 471 NAC 10. The pathologist must claim the professional component of anatomical pathology using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code and modifier. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

~~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.~~

007.02(K)(ii)(1) EXCEPTION. ~~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 laboratory 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:~~ 007.02(K)(ii) OUTPATIENT HOSPITAL ANATOMICAL PATHOLOGY SERVICES. The hospital ~~shall~~ must claim the ~~technical component~~ 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 must claim the professional component. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

~~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.~~

007.02(K)(ii)(1) EXCEPTION. ~~Exception:~~ If an anatomical pathology specimen is obtained from a hospital outpatient and is referred to an independent laboratory or the pathologist of a second hospital's laboratory, the independent laboratory 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:~~ 007.02(K)(iii) 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~~ must 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:~~ 007.02(K)(iv) LEASED DEPARTMENTS. If the pathology department is leased and an anatomical pathology service is provided to a hospital ~~non-patient~~ non-patient, the pathologist ~~shall~~ must 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.

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

~~18-004.33E8 Clinical Lab Services:~~ 007.02(K)(v) CLINICAL LABORATORY SERVICES. The professional and technical components of clinical laboratory 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:~~ 007.02(K)(vi) PHYSICIAN'S OFFICE OR INDEPENDENT LABORATORY. Clinical laboratory services performed in a physician's office or independent laboratory must be billed appropriately. ~~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:~~ 007.02(K)(vi)(1) CLINICAL LABORATORY CONSULTATION. ~~A~~ The physician ~~may~~ must claim a clinical laboratory consultation using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure codes. ~~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:~~ 007.02(L) RADIOLOGY. The professional component must be billed appropriately. ~~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:~~ 007.02(L)(i) INPATIENT RADIOLOGY SERVICES. Payment for the ~~technical component~~ technical component of inpatient radiology services is included in the hospital's payment in accordance with 471 NAC 10. Physicians must bill the professional component of inpatient radiology services appropriately. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

~~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:~~ 007.02(L)(ii) 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 using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code with the modifier. Payment for the professional component is made according to the Nebraska Medicaid Practitioner Fee Schedule.

~~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:~~ 007.02(L)(iii) 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~~ technical 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. Payment is made is made according to the Nebraska Medicaid Practitioner Fee Schedule.

~~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:~~ 007.02(M) SERVICES PROVIDED BY PHYSICIAN ASSISTANTS. Claims for services provided by physician assistants must be submitted on Form CMS-1500: Health Insurance Claim or the standard electronic Health

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

007.02(N) PHYSICIAN SERVICES IN SKILLED NURSING FACILITY (SNF), INTERMEDIATE CARE FACILITY (ICF), AND INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD). The physician may bill the Department for an annual nursing home physical exam service, regardless of the extent of the exam. Additionally, the physician may bill the Department for the recertification service. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

007.02(N)(i) ANNUAL PHYSICAL EXAMINATION. If the annual physical examination is performed solely to meet the requirement of the Department, the physician ~~shall~~ must submit the claim to the Department on Form CMS-1500: Health Insurance Claim 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:~~ 007.02(N)(ii) MEDICARE COVERAGE. If a physical examination is performed for diagnosis ~~and/~~or treatment of a specific symptom, illness, or injury and the ~~client~~ individual has Medicare coverage, the physician ~~shall~~ must 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:~~ 007.02(N)(iii) PHYSICIANS' VISITS TO SKILLED NURSING FACILITY (SNF) RESIDENTS. When billing for a physician's visit, the physician ~~shall~~ must use the appropriate Healthcare Common Procedure Coding System (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:~~ 007.02(N)(iv) 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~~ must use the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for nursing home visits when billing ~~NMAP~~ Nebraska Medicaid 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:~~ 007.02(N)(v) PHYSICIANS' VISITS TO INTERMEDIATE CARE FACILITY (ICF) AND INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD) RESIDENTS. When billing for a physician's visit, the physician ~~shall~~ must use the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code. The physician ~~shall~~ must 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).~~

007.02(O) TRANSPLANT SERVICES. Physician services must be billed accordingly.

~~18-004.40C Billing for Services Provided to an NMAP-Ineligible Donor:~~ 007.02(O)(i) BILLING FOR TRANSPLANT SERVICES PROVIDED TO A MEDICAID-INELLIGIBLE DONOR. Claims for services provided to a~~n~~ ~~NMAP~~ Nebraska Medicaid-ineligible donor must be submitted under the ~~NMAP~~ Nebraska Medicaid-eligible ~~client's~~ individual's case number. There must be a notation with the claim ~~that~~ indicating these services were provided to the ~~NMAP~~ Nebraska Medicaid-ineligible donor on the ~~client's~~ individual'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).~~

007.02(P) ITINERANT PHYSICIAN VISITS. 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.

~~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.~~

007.02(Q) NURSE MIDWIFE OR NURSE PRACTITIONER SERVICES. Claims for nurse-midwife services and nurse practitioner services must be submitted on Form CMS-1500: Health Insurance Claim according to instructions or on the appropriate electronic transaction. ~~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.~~

007.02(R) FEEDING AND SWALLOWING CLINIC SERVICES. The interdisciplinary team (IDT) services must be billed under the physician's provider number accordingly. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule. The physician services are billed under appropriate Current Procedural Terminology (CPT) codes.

007.02(S) COMPREHENSIVE INTERDISCIPLINARY TREATMENT FOR A SEVERE FEEDING DISORDER. Claims must be submitted accordingly.

~~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)~~

008. PAYMENT.

008.01 GENERAL PAYMENT REQUIREMENTS. Nebraska Medicaid will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 3. In the event individual payment regulations in 471 NAC 3 conflict with payment regulations outlined in this chapter, the individual payment regulations in this chapter will govern

008.02 SPECIFIC PAYMENT REQUIREMENTS.

~~18-006 Payment for Physician Services:~~ 008.02(A) REIMBURSEMENT. Nebraska Medicaid pays for covered physician services, except clinical laboratory services, at the lower of the provider's submitted charge or the allowable amount for the procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for the date of service.

~~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:~~ 008.02(A)(i) EXCEPTION. ~~The Director of the Division of Medicaid and Long-Term Care or designee~~ The Department may enter into an agreement with an out-of-state provider for a rate ~~that~~ which exceeds the rate according to the Nebraska Medicaid Practitioner Fee Schedule only when the Department ~~Medical Director of the Division~~ has determined ~~that:~~ the individual requires specialized services which are not available in Nebraska and no other source of the specialized service can be found.

~~a. The client requires specialized services that are not available in Nebraska; and~~

~~b. No other source of the specialized service can be found.~~

008.02(B) SITE OF SERVICE ADJUSTMENT. ~~Reimbursement for services provided by physicians and non-physician care providers is subject to the site-of-service payment adjustment.~~ Nebraska Medicaid applies a site of service differential ~~that~~ which reduces the fee schedule amount for specific Current Procedural Terminology (CPT) and ~~/~~ Healthcare Common Procedure Coding System (HCPCS) codes when the service is provided in a facility setting. Based on the Medicare differential, ~~Medicaid~~ the Department will reimburse specific Current Procedural Terminology (CPT) and ~~/~~ Healthcare Common Procedure Coding System (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.~~

008.02(C) ~~Non-Payment of Other Provider Preventable Conditions (OPPCs):~~ NON-PAYMENT OF OTHER PROVIDER PREVENTABLE CONDITIONS (OPPC). ~~Effective on or after the effective date of this regulation for~~ For physician and non-physician provider claims, payment will be denied for the following Other Provider Preventable Conditions (OPPCs):

~~1.~~(i) Wrong surgical or other invasive procedure performed on an individual ~~patient~~;

~~2.~~(ii) Wrong surgical or other invasive procedure performed on the wrong body part; and

~~3.~~(iii) Wrong surgical or other invasive procedure performed on the wrong individual ~~patient~~.

008.02(D) SURGERY. The surgical procedure, including 14 days post-operative care, is reimbursed under a Healthcare Common Procedure Coding System (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 which add significant time and complexity to patient

care are reimbursed at one-half of the amount which would be paid if the procedure were the primary procedure.

008.02(D)(i) ASSISTANT SURGEON. When an assistant surgeon is required, reimbursement is made according to the Nebraska Medicaid Practitioner Fee Schedule.

008.02(E) PRACTITIONER ADMINISTERED MEDICATIONS. The Department will reimburse practitioner administered injectable medications at 100 percent of the Medicare

Drug Fee Schedule plus an administration fee as listed. Injectable medications approved by the Department but not included on the Medicare Drug Fee Schedule will be reimbursed at the wholesale acquisition cost (WAC) plus 6.8 percent.

008.02(E)(i) ALLERGY INJECTIONS. When the cost of the medication is 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 or the supplier bills the Department separately, the Department reimburses the administering physician according to the Medicaid Practitioner Fee Schedule for the injection fee. If the administering physician purchases the supply for administration in the 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.

008.02(E)(ii) IMMUNIZATIONS. The Department reimbursement is available for the provider’s private stock vaccine and the administration fee for immunizations of adolescents age 19 and 20.

008.02(F) LABORATORY AND PATHOLOGY.

008.02(F)(i) PHYSICIAN’S OFFICE OR INDEPENDENT LABORATORY. Payment is based on the Nebraska Medicaid fee schedule for clinical laboratory services to cover the total service, both professional and technical components.

008.02(F)(i)(1) PHYSICIAN’S OFFICE LABORATORY. Payment for tests obtained in the physician's office but sent to an independent clinical laboratory or hospital for processing must be claimed by the facility performing the tests, using the appropriate Healthcare Common Procedure Coding System (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 Healthcare Common Procedure Coding System (HCPCS) procedure code at the providers' submitted charge up to 100 percent of the Medicare clinical laboratory fee schedule. The Department does not reimburse the private physician for processing or interpreting tests performed outside their office.

008.02(F)(ii) CLINICAL LABORATORY SERVICES. 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.

008.02(F)(ii)(1) LICENSED AND CERTIFIED INDEPENDENT CLINICAL LABORATORY. When a physician's private office sends the specimen to an independent clinical laboratory for processing, the Department pays for the procedure directly to the independent clinical laboratory. The Department does not reimburse the laboratory 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 laboratory for hospital or independent laboratory patients. The Department does not reimburse the private physician for processing or interpreting tests performed outside their 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 their office plus a fee for drawing the specimen by venipuncture or obtaining urine by catheterization sent to a hospital or independent laboratory.

008.02(F)(ii)(2) HOSPITAL CLINICAL LABORATORY SERVICES. Payment is made to the hospital as follows. There is no separate payment made to the pathologist for routine clinical laboratory services. To be paid, the pathologist must negotiate with the hospital to arrange a salary or compensation agreement.

(a) INPATIENT SERVICES. Payment is included in hospital's prospective payment rate in accordance with 471 NAC 10;
(b) OUTPATIENT SERVICES. Payment is made according to the fee schedule determined by the Department; and
(c) NON-PATIENT SERVICES. Payment is made according to the fee schedule determined by the Department.

008.02(G) PROFESSIONAL COMPONENT OF HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES. The Department pays for the professional component of a physician's hospital diagnostic or therapeutic service as described previously. 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 previously, 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.

008.02(H) ANESTHESIOLOGY SERVICES. The Department pays for covered anesthesiology services in accordance with the reimbursement rates previously described. The Department does not make additional reimbursement for emergency and risk factors.

008.02(H)(i) PAYMENT FOR CERTIFIED REGISTERED NURSE ANESTHETISTS SERVICES. These services are paid according to the Nebraska Medicaid Practitioner Fee Schedule.

008.02(I) PAYMENT FOR SERVICES PROVIDED BY PHYSICIAN ASSISTANTS. 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. The Department will not make payments to physicians assistants who are employed by a hospital.

008.02(J) PAYMENT FOR TRANSPLANT SERVICES. The provider must submit, at the request of the Department, any medical documentation from the individual's record to support and substantiate claims submitted to the Department for payment.

008.02(J)(i) HOSPITAL SERVICES. For information on payment of inpatient and outpatient hospital services in accordance with 471 NAC 10.

008.02(J)(ii) PHYSICIAN SERVICES. Surgeon 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.

008.02(K) ITINERANT PHYSICIAN VISITS. The physician will be paid at the rate for the appropriate level of office visit.

008.02(L) NURSE MIDWIFE SERVICES. Payment for nurse midwife services is made to the group with whom the nurse-midwife has a practice agreement.

008.02(M) COMPREHENSIVE INTERDISCIPLINARY TREATMENT FOR A SEVERE FEEDING DISORDER.

008.02(M)(i) 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 Nebraska Medicaid enrolled licensed practitioners.

008.02(M)(ii) PEDIATRIC FEEDING DISORDER CLINIC OUTPATIENT TREATMENT. Pediatric feeding disorder clinic outpatient treatment for medically necessary services is reimbursed at the appropriate fee schedule amount for a physician consultation for covered services provided by Nebraska Medicaid enrolled licensed practitioners.

~~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.

4. 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.
5. 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
6. 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.
7. 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
8. 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.~~

009. PRESCRIPTION DRUG MONITORING PROGRAM.

009.01 GENERAL REQUIREMENT. Each provider prescribing a controlled substance in Nebraska to a Medicaid client must check the prescription drug monitoring program established under Neb. Rev. Stat. § 71-2454 before prescribing a schedule II medication and at dosage adjustment. Provider may delegate checking of the prescription drug monitoring program to a delegate as defined in Neb. Rev. Stat. § 71-2454 (14)(c).

009.02 EXCEPTION. Good faith exceptions must be documented in the client's medical record and provided upon request to the Department. These requirements do not include a prescription to a client as set forth under 42 U.S.C. Sec. 1396w-3a and to a resident of a facility where schedule II medications are dispensed to a client through a single pharmacy.