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NEBRASKA DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

471 NAC 18

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 18 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.

#### 003.02 SPECIFIC PROVIDER REQUIREMENTS.

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) When state or applicable local law requires licensing of independent clinical laboratories, the laboratory must be licensed under the law; and
- (ii) The laboratory must meet the health or safety requirements of the United States Secretary of Health and Human Services.

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 lysosomal 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.

005.01 FACILITY-BASED PHYSICIAN CLINICS. Physician clinic services provided in a hospital location or a facility under the hospital's licensure are considered to be a physician service, not an outpatient hospital service.

- (A) 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.
- (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:
  - (i) Of the type commonly furnished in a physician's office;
  - (ii) Furnished as an incidental, although integral, part of the physician professional service; and
  - (iii) Furnished under the direct personal supervision of the physician.

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 psuedoarthroses.

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 its 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 tomography (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 tomography (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 tomography (CT) scan must be medically appropriate considering the individual's symptoms and preliminary diagnosis. The Department may determine the use of a computerized tomography (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 tomography (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 facilities 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 facilities 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.

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.

006.01 SURGICAL PROCEDURES. Nebraska Medicaid does not cover:

- (A) Acupuncture;
- (B) Angiocardiology, single plane, supervision and interpretation in conjunction with cineradiography or multi-plane, supervision and interpretation in conjunction with cineradiography;
- (C) Angiocardiology, utilizing CO<sub>2</sub> method, supervision and interpretation only;
- (D) Angiography, coronary, unilateral selective injection supervision and interpretation only, single view unless emergency;
- (E) Angiography, extremity, unilateral, supervision and interpretation only, single view unless emergency;
- (F) Ballistocardiogram;
- (G) Basal metabolic rate (BMR);
- (H) Bronchoscopy, with injection of contrast medium for bronchography or with injection of radioactive substance;
- (I) Circumcision, female;
- (J) Excision of carotid body tumor, with or without excision of carotid artery, when used as a treatment for asthma;
- (K) Extra-intra cranial arterial bypass for stroke;
- (L) Fabric wrapping of abdominal aneurysm;
- (M) Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain;
- (N) Fascia lata by stripper when used as a treatment for lower back pain;
- (O) Hypogastric or presacral neurectomy as an independent procedure;
- (P) Hysterotomy, non-obstetrical, vaginal;
- (Q) Icterus index;
- (R) Ileal bypass or any other intestinal surgery for the treatment of obesity;
- (S) Kidney decapsulation, unilateral and bilateral;

- (T) Ligation of femoral vein, unilateral and bilateral, when used as treatment for post-phlebotic syndrome;
- (S) Ligation of internal mammary arteries, unilateral or bilateral;
- (U) Ligation of thyroid arteries as an independent procedure;
- (V) Nephropexy: fixation or suspension of kidney as an independent procedure, unilateral;
- (W) Omentopexy for establishing collateral circulation in portal obstruction;
- (X) Perirenal insufflation;
- (Y) Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study;
- (Z) Protein bound iodine (PBI);
- (AA) Radical hemorrhoidectomy, whitehead type, including removal of entire pile bearing area;
- (BB) Refractive keratoplasty, includes keratomileusis, keratophakia, and radial keratotomy;
- (CC) Reversal of tubal ligation or vasectomy;
- (DD) Sex change procedures;
- (FF) Solid organ transplants performed in a facility which is not included on the list of Medicare-approved transplant programs;
- (GG) Splanchnicectomy, unilateral or bilateral, when used as a treatment for hypertension;
- (HH) Supracervical hysterectomy: subtotal hysterectomy, with or without tubes or ovaries, one or both;
- (II) Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as a treatment for hypertension; or
- (JJ) Uterine suspension, with or without presacral sympathectomy.

006.02 OBSOLETE TESTS. 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:

- (A) Amylase, blood isoenzymes, electrophoretic;
- (B) Chromium, blood;
- (C) Guanase, blood;
- (D) Zinc sulphate turbidity, blood;
- (E) Skin test, cat scratch fever;
- (F) Skin test, lymphopathia venereum;
- (G) Circulation time, one test;
- (H) Cephalin flocculation;
- (I) Congo red, blood;
- (J) Hormones, adrenocorticotropin quantitative animal tests;
- (K) Hormones, adrenocorticotropin quantitative bioassay;
- (L) Thymol turbidity, blood;
- (M) Skin test, actinomycosis;
- (N) Skin test, brucellosis;
- (O) Skin test, leptospirosis;
- (P) Skin test, psittacosis;
- (Q) Skin test, trichinosis;
- (R) Calcium, feces, 24-hour quantitative;
- (S) Starch; feces, screening;

- (T) Chymotrypsin, duodenal contents;
- (U) Gastric analysis pepsin;
- (V) Gastric analysis, tubeless;
- (W) Calcium saturation clotting time;
- (X) Capillary fragility test;
- (Y) Colloidal gold;
- (Z) Bendien's test for cancer and tuberculosis;
- (AA) Bolen's test for cancer; and
- (BB) Rehfuss test for gastric acidity.

006.03 SERVICES REQUIRED TO TREAT COMPLICATIONS OR CONDITIONS RESULTING FROM NON-COVERED SERVICES. Nebraska Medicaid may consider coverage of medically necessary services 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.

006.04 SERVICES NOT REASONABLE AND NECESSARY. 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.

006.05 SURGICAL ASSISTANT FEES. 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.

- (A) Laparoscopy, including laparoscopic tubal ligation;
- (B) Tonsillectomy, adenoidectomy, myringotomy;
- (C) Conservative or closed fracture care; and
- (D) Uncomplicated procedures of the integument.

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.

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

- (A) Procedures involving fluoroscopy;



- (B) Procedures involving the use of contrast media;
- (C) Procedures requiring the administration of a substance to the individual or injection of a substance into the individual or special manipulation of the individual;
- (D) Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require medical judgment be exercised;
- (E) Procedures requiring special technical competency or special equipment or materials;
- (F) Routine screening procedures; and
- (G) Procedures which are not of a diagnostic nature.

006.08 NON-COVERED DRUG SERVICES. Payment by Nebraska Medicaid will not be approved for:

- (A) Requests for quantities not in compliance with 471 NAC 16;
- (B) Experimental drugs or non-Food and Drug Administration (FDA) approved drugs;
- (C) Drugs or items when the prescribed use is not for a medically accepted indication;
- (D) Drugs or items prescribed or recommended for weight control or appetite suppression;
- (E) Liquors;
- (F) Drug Efficacy Study Implementation Program (DESI) drugs identified as less than effective (LTE) or identical, related, or similar (IRS) with an indicator value assigned by the Food and Drug Administration (FDA) of either five or six;
- (G) Personal care items;
- (H) Medical supplies and certain drugs for nursing facility and intermediate care facility for individuals with developmental disabilities (ICF/DD) residents, see 471 NAC 7 and 16;
- (I) Over-the-counter (OTC) drugs not listed on the Nebraska Point of Sale system or on the Department's web site;
- (J) Drugs or items used for cosmetic purposes or hair growth;
- (K) Baby foods or metabolic agents normally supplied by the Department, see 471 NAC 16 for exceptions;
- (L) Drugs distributed or manufactured by certain drug manufacturers or labelers who have not agreed to participate in the drug rebate program;
- (M) Products used to promote fertility;
- (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;
- (P) Drugs, items, or products of manufacturers or labelers which are identifiable as non-covered on the Nebraska Point of Sale system or on the Department's website;
- (Q) Drugs, classes of drugs, or therapeutic categories of drugs which are Medicare Part D drugs and Medicare Part D covered supplies or equipment, for all persons eligible for benefits under Medicare Part D, whether or not such persons are enrolled into a Medicare Part D plan;
- (R) Drugs or classes of drugs approved by the Food and Drug Administration (FDA) for treatment of sexual or erectile dysfunction, or drugs or classes of drugs which are being used for the treatment of sexual or erectile dysfunction. Drugs or classes of drugs which are approved by the Food and Drug Administration (FDA) for treatment of sexual or erectile dysfunction and for conditions other than treatment of sexual or

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erectile dysfunction, and are prescribed for those other conditions may be covered, but Nebraska Medicaid may require prior authorization. See 471 NAC 16; and (S) Automatic Refills, see 471 NAC 16.

006.09 INFLUENZA INJECTIONS IN LONG-TERM CARE FACILITIES. No payment is made to a physician giving influenza injections in long-term care facilities.

006.10 INJECTABLE ESTROGENS. Nebraska Medicaid does not pay for injectable estrogens for depression or osteoporosis associated with menopause.

006.11 LIVER AND VITAMIN INJECTIONS. 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 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.

007.02(F)(i) CHEMOTHERAPY. Providers must bill for chemotherapy using Healthcare Common Procedure Coding System (HCPCS) procedure codes for chemotherapy administration. 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 which do not have a specific Healthcare Common Procedure Coding System (HCPCS) code, the provider must use a miscellaneous chemotherapy code. The provider must indicate on or in the claim the name of medication, the dosage administered, and the National Drug Code (NDC) number, unit of measure, and number of units.

007.02(F)(ii) IMMUNIZATIONS. When using Vaccine for Children (VFC) vaccines, only the administration is billed to Nebraska Medicaid by adding the appropriate modifier to the vaccine code. The billed charge for the administration must not exceed the Vaccine for Children (VFC) federally determined state maximum for Nebraska.

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, 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.

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.

007.02(J)(ii) CLAIMS FOR PAYMENT. When a physician bills for anesthesia services, the physician 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 completed copy of Form MMS-100: Sterilization Consent Form 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.

007.02(K) LABORATORY AND PATHOLOGY.

007.02(K)(i) INPATIENT HOSPITAL ANATOMICAL PATHOLOGY SERVICES. Payment for the 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.

007.02(K)(ii)(1) 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. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

007.02(K)(ii) OUTPATIENT HOSPITAL ANATOMICAL PATHOLOGY SERVICES. The hospital must claim the technical component according to 471 NAC 10. The pathologist must claim the professional component. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

007.02(K)(ii)(1) 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. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

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 must bill the total service. Payment is made according to 471 NAC 10.

007.02(K)(iv) LEASED DEPARTMENTS. If the pathology department is leased and an anatomical pathology service is provided to a hospital non-patient, the pathologist must claim the total service. 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.

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007.02(K)(v) CLINICAL LABORATORY SERVICES. The professional and technical components of clinical laboratory services are not separately identified for billing and payment.

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.

007.02(K)(vi)(1) CLINICAL LABORATORY CONSULTATION. The physician must claim a clinical laboratory consultation using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure codes.

007.02(L) RADIOLOGY. The professional component must be billed appropriately.

007.02(L)(i) INPATIENT RADIOLOGY SERVICES. Payment for the 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.

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. Payment is made according to 471 NAC 10. 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.

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 technical component. Payment is made according to 471 NAC 10. 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 according to the Nebraska Medicaid Practitioner Fee Schedule.

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.

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 certification 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 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.

007.02(N)(ii) MEDICARE COVERAGE. If a physical examination is performed for diagnosis or treatment of a specific symptom, illness, or injury and the individual has Medicare coverage, the physician must submit the claim through the usual Medicare process. This applies to all physicians' visits in a long-term care facility.

007.02(N)(iii) PHYSICIANS' VISITS TO SKILLED NURSING FACILITY (SNF) RESIDENTS. When billing for a physician's visit, the physician must use the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for a nursing home visit.

007.02(N)(iv) ON-SITE RECERTIFICATION. The physician is paid according to the Nebraska Medicaid Practitioner Fee Schedule. The physician must use the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for nursing home visits when billing Nebraska Medicaid for this service.

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 must use the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code. The physician must submit following statements on or with the claim: "60-day (or alternate schedule) intermediate examination."

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

007.02(O)(i) BILLING FOR TRANSPLANT SERVICES PROVIDED TO A MEDICAID-INELIGIBLE DONOR. Claims for services provided to a Nebraska Medicaid-ineligible donor must be submitted under the Nebraska Medicaid-eligible individual's case number. There must be a notation with the claim indicating these services were provided to the Nebraska Medicaid-ineligible donor on the individual's behalf.

007.02(P) ITINERANT PHYSICIAN VISITS. The hospital room charge must be 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.

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.

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.

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.

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.

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

008.02(B) SITE OF SERVICE ADJUSTMENT. Nebraska Medicaid applies a site of service differential 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, 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.

008.02(C) NON-PAYMENT OF OTHER PROVIDER PREVENTABLE CONDITIONS (OPPC). For physician and non-physician provider claims, payment will be denied for the following Other Provider Preventable Conditions (OPPCs):

- (i) Wrong surgical or other invasive procedure performed on an individual;
- (ii) Wrong surgical or other invasive procedure performed on the wrong body part; and
- (iii) Wrong surgical or other invasive procedure performed on the wrong individual.

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.

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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.

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).

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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.