TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 33 HEALTH CHECK (EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT [EPSDT]) 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 CONTINUING CARE. The provision of HEALTH CHECK preventive, acute, and chronic care services by a single provider, who coordinates care, maintains a consolidated medical record of the child, and is the child's regular source of health care.

002.02 DIAGNOSTIC. The determination of the nature or cause of a physical or mental disease or abnormality.

002.03 EARLY. The practice of assessing and identifying problems as soon as an individual's or a family's eligibility for assistance has been established; or, in the case of a family already receiving assistance, as early as possible in the individual's life. This includes informing Medicaid-eligible pregnant women so that prevention begins prenatally.

002.04 ENVIRONMENTAL LEAD INVESTIGATION. An assessment of the child's home or primary residence by a health professional certified as a lead inspector using a portable x-ray fluorescence (XRF) analyzer.

002.05 EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT). Federally mandated program for children under age 21 that requires states to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines.

002.06 PERIODIC. Checking children's health at age-appropriate intervals established for examination or screening to ensure continued health and to detect conditions requiring treatment.

002.07 SCREENING SERVICES. Regularly scheduled periodic child health assessments to examine and evaluate the general physical and mental health, growth, development, and nutritional status of eligible children. The screenings are performed to identify individuals who may require diagnosis, further examination, and treatment.

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. To participate in Nebraska Medicaid, providers of HEALTH CHECK services must comply with all applicable provider participation requirements codified in 471 NAC 2 and 3. In the event that provider participation requirements in 471 NAC 2 or 3 conflict with requirements outlined in this 471 NAC 33, the individual provider participation requirements in 471 NAC 33 will govern.

003.02 SERVICE SPECIFIC PROVIDER REQUIREMENTS.

003.02(A) SCREENING PROVIDERS. Screening services must be performed by or under the supervision of a physician, dentist, or other provider licensed under State or Federal law to furnish primary medical and health services. Periodic and interperiodic examinations must, at a minimum, include the health screening services defined within this chapter. Vision and hearing screening examinations cannot be limited to the screening physician but may be obtained directly from an ophthalmologist or optometrist for vision services and licensed audiologist for the hearing service.

003.02(B) CONTINUING CARE PROVIDERS. Managed care plans will be considered continuing care providers if the following provisions are met. A continuing care provider is one who:

(1) Agrees to provide to formally enrolled children screening, diagnosis, and treatment for conditions identified during screening or referral to a provider capable of providing the appropriate services. As appropriate, the formal enrollment means that the HEALTH CHECK-eligible child or family has agreed to use one provider as a regular source of continuing care services for a stated period of time, and that mutual obligations of both client and provider are recognized by signed enrollment agreement;
(2) Maintains a complete health history, including information received from other providers;
(3) Is responsible for providing needed physician services for acute, episodic, and chronic illnesses and conditions;
(4) Ensures accountability by submitting reports reasonably required by the Department; and
(5) Works with the HEALTH CHECK case manager, if one is assigned.

003.02(B)(i) ENROLLMENT AGREEMENT. The enrollment agreement must specify what options the provider will use to provide the following HEALTH CHECK services:

(1) Provision of dental services, or direct referral to a dentist or referral to the Department to obtain dental services;
(2) Provision of all or part of the required transportation and scheduling assistance, or referral to the Department to obtain such assistance; and
(3) Referral assistance for treatment not covered by the plan but needed, or referral to the Department to obtain assistance as well as other provisions outlined in the agreement.

003.02(C) HEALTH CHECK SPECIAL SERVICES. All providers of the following special services must be licensed Nebraska Medicaid-enrolled providers who have submitted written required documentation and received written approval from the Department. All providers requesting to provide the following HEALTH CHECK special services must submit a request in writing.

003.02(C)(i) NUTRITIONAL COUNSELING. Physicians providing HEALTH CHECK services or licensed medical nutrition therapists may be approved to provide nutritional counseling. Those requesting to provide this service must submit a written request and include (1) person(s) providing services and their credentials, (2) general content of nutritional counseling session, (3) conditions most frequently expected to be encountered, (4) usual length and frequency of sessions, and (5) customary charge. The Department may request periodic review of the services. Requests for reapproval must be submitted when a change in approved content occurs. A referral must be made to the Special Supplemental Food Program for Women, Infants, and Children (WIC) for ongoing nutritional counseling for children under five, or for lactating, postpartum, or pregnant women.

003.02(C)(ii) LACTATION COUNSELING. The following providers may provide all lactation counseling services: physician, nurse practitioner (NP), physician assistant (PA), midwife (MW), and registered nurse (RN). Any such provider must have current certification as an International Board Certified Lactation Consultant. The Department may request periodic review of the services.

003.02(C)(iii) CHILDBIRTH EDUCATORS. Licensed practitioners who are Lamaze Certified Childbirth Educator (LCCE) or Certified Childbirth Educator (CCCE) and request to provide this service for Nebraska Medicaid-eligible individuals age 20 and younger must complete Form MC-19: Medical Assistance Provider Agreement, and return the form with a letter stating the class type, general description, class outline or statement of content, and length of sessions for initial approval. Childbirth educators must include proof of certification or course completion by a recognized childbirth education association. Requests for reapproval must be submitted when a change in the initial proposal occurs. The Department may request periodic review of the services. Requests to approve changes to approved services must be submitted to the Department. Approval is based on guidelines from recognized childbirth education associations and demonstrate appropriateness.

003.02(C)(iv) WELL CHILD CLUSTER VISITS. Providers interested in providing this service must submit a description of the cluster visit, including format, group size, scheduling, and content to the Department to request initial prior approval. Requests to approve any changes to the approved service must be submitted to the Department.

004. SERVICE REQUIREMENTS.

004.01 GENERAL SERVICE REQUIREMENTS. HEALTH CHECK, the Nebraska Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, is a service available to all individuals age 20 and younger eligible for medical assistance. The HEALTH CHECK

Program ensures the availability and accessibility of required health care resources and aids Nebraska Medicaid-eligible children and their parents or caretakers effectively use them.

004.01(A) PRIOR AUTHORIZATION. Unless otherwise outlined, all services not covered by the Department must be prior authorized by the Department. The provider must submit requests for prior authorization using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) or by completing and submitting a written request. The plan of care may be submitted on Form EPSDT-5: Plan of Care or as a statement by the screening practitioner. If the initial request is denied, additional information may be sent for reconsideration. A request for prior authorization must include:

(i) A copy of the screening exam form or the name of the screening practitioner and the date of the screening exam that identified the condition; and

(ii) A plan of care that includes:

(1) History of the condition;

(2) Physical findings and other signs and symptoms, including appropriate laboratory data;

(3) Recommended service or procedure, including the potential provider of service or where the services will be obtained;

(4) Estimated cost, if available; and

(5) Expected outcome(s).

004.01(B) MEDICAL NECESSITY. The Department incorporates the medical necessity requirements outlined in 471 NAC 1 as if fully rewritten herein. Services and supplies that do not meet the requirements in 471 NAC 1 are not covered.

004.02 COVERED SERVICES.

004.02(A) HEALTH CHECKS. The screening examination is performed to identify those health problems that require further examination and treatment. The Recommendations for Preventive Pediatric Health Care published by the American Academy of Pediatrics are recommended as guidelines for content and minimum frequency for HEALTH CHECK examinations. The physician may establish an alternate periodicity schedule based on medical necessity. The initial newborn assessment in the hospital is considered a HEALTH CHECK screening. Total obstetrical care fulfills the requirement of a HEALTH CHECK examination for HEALTH CHECK participants. Claims for screening exams will be subject to random selection of medical chart review to ensure the minimum components of the screening examination are performed.

004.02(A)(i) COMPONENTS OF HEALTH SCREENING. Each health screening must include the minimum components identified and outlined in 471 NAC 33-004.02(A)(i)(1) through 471 NAC 33-004.02(A)(i)(5); and at the screening physician's judgment, the components in 471 NAC 33-004.02(A)(i)(6) through 471 NAC 33-004.02(A)(i)(8).

004.02(A)(i)(1) HEALTH AND DEVELOPMENTAL HISTORY. A comprehensive history must be obtained on the initial examination and updated at subsequent

periodic examinations. If a formal development test is given to assess development, it may be covered separately from the full screening package by the screening physician if that is the physician's customary practice. The history is to include:

(a) Contact information;
(b) A description of the family;
(c) Medical, developmental and behavioral information of the child and the family;
(d) Assessment of nutritional status to determine whether the child has any symptoms related to nutritional status; and
(e) A risk assessment of children and adolescents for early identification of mental health or substance use concerns.

004.02(A)(i)(2) COMPREHENSIVE UNCLOTHED PHYSICAL EXAMINATION. This component must be performed during each initial and subsequent periodic examination, and must include a physical growth evaluation, a check of the general appearance of the child to determine overall health status, and a check of the organ systems.

004.02(A)(i)(3) IMMUNIZATIONS. In order to obtain appropriate immunizations for age and health history, assessment of the immunization status must be determined at each screening examination, and updated according to the most current immunization schedule of the Advisory Committee on Immunization Practices (ACIP) or American Academy of Pediatrics (AAP). Immunizations must be given at the time of the screening examination unless medically contraindicated.

004.02(A)(i)(3)(a) CHILDREN AND ADOLESCENTS AGE 18 AND YOUNGER. Medicaid does not cover a physician’s private stock vaccine when the vaccine is available through the Vaccine for Children Program (VFC) program.

004.02(A)(i)(3)(b) ADOLESCENTS AGE 19 AND 20. The Department covers routine preventative immunizations under the HEALTH CHECK program. The Department covers the physician’s private stock vaccine plus an administration fee for immunization of these individuals.

004.02(A)(i)(4) LABORATORY TESTS. The Department covers appropriate laboratory procedures, including blood lead testing for identified age and populations groups, as determined by the screening physician. Tests may include but are not limited to:

(a) HEMOGLOBIN AND HEMATOCRIT. A microhematocrit determination or hemoglobin concentration test from venous blood or a finger stick according to the American Academy of Pediatrics Recommendations for Pediatric Preventive Health Care;
(b) SICKLE CELL. If indicated by population group.

(c) TUBERCULIN TESTING. (Purified Protein Derivative [PPD]). Tuberculin testing is recommended annually for children with risk factors;

(d) LEAD TOXICITY SCREENING. An assessment of risk of high-dose lead exposure and blood lead testing by either capillary or venipuncture collection method. All children ages 6-72 months of age are considered at risk for lead poisoning and must be assessed. If the answers to all of the following questions are negative, a child is considered at low risk for high doses of lead exposure but is to receive a blood lead test at 12 months and 24 months. If the answer to any of the following questions is positive, a child is considered at high risk and a blood lead test must be obtained immediately and at subsequent screening examinations. In addition, any child between the ages of 25 and 72 months with no record of a previous blood lead screening must receive one. Physicians are to reference Centers for Disease Control (CDC) guidelines for patient management and treatment. A provider must ask the following risk assessment questions:

(i) Does your child live in or regularly visit a house built before 1978? Does the house have peeling or chipping paint?

(ii) Does your children live in a house built before 1978 with recent, ongoing, or planned renovation or remodeling?

(iii) Has your child or anyone that your child has come into contact with had lead poisoning?

(iv) Does your child frequently come in contact with an adult who works with lead (construction, welding, pottery)?

(v) Does your child live near a lead smelter, battery-recycling plant, or other industry likely to release lead?

(vi) Do you use any home or folk remedies that may contain lead?

(vii) Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?

(viii) Does your home's plumbing have lead pipes or copper with lead solder joints?

(xi) Has your child had a blood lead test in the last 12 months?

(e) ENVIRONMENTAL INVESTIGATION. Patient specific environmental investigations must be covered if the physician has diagnosed lead toxicity, and blood lead testing by venipuncture method shows that the child's blood lead level is above 10 micrograms per deciliter. Non-medical activities such as removal of lead sources, providing alternate housing, or analysis of samples that are sent to laboratories are not covered. The environmental investigation must include:

(i) An interview with the family to gather basic information about the habits of the child and provide information about source of lead exposure, nutritional guidelines, prevention, and clean-up advice; and

(ii) Written recommendations to the owner of the house or apartment for the immediate and permanent removal or reduction of the lead sources.

(f) URINALYSIS. A rapid screening or dip test to detect the presence of sugar and albumin;

(g) SERUM CHOLESTEROL DETERMINATION. If indicated; and

(h) OTHERS. Other tests that may be determined appropriate in accordance with the periodicity schedule based on individual's age, sex, health history, clinical symptoms, and exposure to disease.

004.02(A)(i)(5) HEALTH EDUCATION AND ANTICIPATORY GUIDANCE. The provider must give the parent(s), caretaker, and child anticipatory guidance or assistance in understanding what to expect in terms of the child's development, and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention. Health education is to be part of the initial and subsequent periodic examinations. This includes nutritional education or counseling when done by the assessing physician or auxiliary staff that does not require management by a medical nutritional therapist.

004.02(A)(i)(6) VISION SCREEN. Age appropriate visual assessment, including medically necessary and reasonable diagnosis and treatment for defects in vision. Vision screening may be obtained directly from a qualified provider of these screening services. Vision services will be covered as provided in 471 NAC 24. Vision screening must be performed to detect problems in acuity, color blindness, and ocular alignment.

004.02(A)(i)(6)(a) VISION SCREEN WITHIN THE CONTEXT OF THE HEALTH SCREEN. Screening for visual problems for children from birth to age three may be subjective through history taking and observation. Beginning at age three, if the child can safely be tested, testing is recommended at each periodic health screening or more often when medically indicated.

004.02(A)(i)(6)(b) REFERRAL CRITERIA GUIDELINES. Children with any ocular signs or symptoms such as blurred vision; squinting; wandering eye; crossed eye; excessive blinking; itchy, burning, or scratchy eyes; red eye or eyelid; swollen or crusted eyelid; headache if associated with reading or other demanding visual task should be referred to an optometrist or ophthalmologist. Additionally, children who fail any of the following tests must be referred to an optometrist or ophthalmologist:

(i) Any abnormality of the external or internal eye as detected with the ophthalmoscope;
(ii) Visual acuity with a two-line difference between eyes; visual acuity of 20/50 or worse in either eye for children three-five years old; visual acuity of 20/40 or worse in either eye for children six and older;
(iii) Inability of either eye to follow a penlight through a full range of motion. Wandering, turning, or jumping of the eyes when the eyes are alternately covered while the child is carefully watching a small distant object. Wandering, turning, or jumping of the eyes when repeated while the child focuses on a small object at reading distance; or
(iv) Failure to discriminate color is not necessarily a basis for referral, but the child and family should be counseled concerning any deficit.

004.02(A)(i)(6)(c) VISION SCREEN PERFORMED BY OPHTHALMOLOGIST OR OPTOMETRIST. The Department covers annual eye examinations for HEALTH CHECK participants beginning at age three. More frequent exams will also be covered if needed to determine the existence of suspected conditions.

004.02(A)(i)(7) HEARING SCREEN. Age appropriate hearing assessment, including medically necessary and reasonable diagnosis and treatment for defects in hearing. The hearing screening may be obtained directly from a qualified provider of these screening services. Hearing services will be covered as provided in 471 NAC 23. Hearing screening must be performed to detect problems in hearing loss and speech development.

004.02(A)(i)(7)(a) REFERRAL CRITERIA GUIDELINES. Appropriate overall criteria for referral may be based on a failed response of 30 dB or greater in any frequency in either ear. Beginning at age three, if the child can safely be tested, audiometric screening is appropriate.

004.02(A)(i)(7)(b) HEARING SCREEN WHEN PERFORMED BY A LICENSED AUDIOLOGIST. Hearing screening examinations are those performed with no connection to treatment or diagnosis for a specific illness, symptoms, complaint, or injury. The examination must follow the standards outlined by the American Speech-Language Hearing Association (ASHA) for pure tone screening. The hearing periodicity schedule outlines the recommended and appropriate minimum frequency for hearing screening examination. Frequent exams will be covered if needed to determine the existence of suspected problems. Hearing screening examinations or for HEALTH CHECK participants do not require prior authorization for payment. Hearing services will be covered as provided in 471 NAC 23.

004.02(A)(i)(8) DENTAL SCREENING. The dental screening examination must be performed to detect deterioration of hard tissues and inflammation or swelling of soft tissues. For children under the age of 21, this may be performed by a visual inspection of the palate and dental ridge as part of the health screening examination. A direct referral to a dentist is required beginning at age one as indicated on the health screening periodicity schedule or earlier if determined medically necessary. Thereafter, dental screening examinations are authorized at six-month intervals or more frequently based on medical necessity. Additionally, more frequent dental examinations are authorized to determine the existence of suspected conditions. Dental screening examinations for HEALTH CHECK participants do not require prior authorization for payment. Dental services will be covered as provided in 471 NAC 6.

004.02(A)(i)(8)(a) ORTHODONTIC TREATMENT. Medicaid covers orthodontic treatment for individuals age 20 and younger in accordance with 471 NAC 6.

004.02(B) PERIODICITY SCHEDULES. The minimum required guidelines for health screening examinations can be found in "Recommendations For Preventive Pediatric Health Care" published by the American Academy of Pediatrics. Wards of the Department may be screened each time they are placed in a foster home or facility. Physical examinations may be performed when necessary for school, camp, or similar activity.

004.02(C) INTERPERIODIC SCREENING. Interperiodic screening examinations, performed outside of the periodicity schedule, will be covered when medically necessary to:

(1) Diagnose an illness or condition that was not present at the regularly scheduled screening; or
(2) Determine if there has been a change in a previously diagnosed illness or condition that requires additional services.

004.02(C)(i) INTERPERIODIC SCREENING DETERMINATION. The determination of whether an interperiodic screening is medically necessary may be made by the child's physician or dentist, or by a health, developmental, or educational professional who comes into contact with the child outside of the formal health care system. If the minimum components of a periodic health screening as previously defined are not performed, and only illness care is provided, the service should be reported and claimed as an acute care service. These visits require that a complete HEALTH CHECK screen be done.

004.02(D) DIAGNOSIS SERVICES. If, under certain circumstances, a diagnosis is not provided at the same time as screening, the Department covers diagnosis services provided during a second appointment. The diagnosis may or may not require further follow-up and may result in referral for treatment.

004.02(E) TREATMENT SERVICES. HEALTH CHECK follow-up services necessary to diagnose or to treat a condition identified during a HEALTH CHECK health, visual, hearing, or dental screening examination are covered under the following conditions:

(1) The service is required to treat a condition (to correct or ameliorate defects and physical or mental illnesses or conditions) that has been identified and documented during a periodic or interperiodic HEALTH CHECK screening examination;
(2) The provider of services is a Nebraska Medicaid-enrolled provider;
(3) The service is consistent with applicable federal and state laws that govern the provision of health care; and
(4) The service must be medically necessary, safe and effective, not considered experimental or investigational and must be generally employed by the medical profession.

004.02(E)(i) SUPPLIES, ITEMS, OR EQUIPMENT. Supplies, items, or equipment that is determined to be not medical in nature will not be covered.

004.02(E)(ii) ALTERNATIVE SERVICES. Where alternative and medically appropriate modes of treatment exist and are available, Medicaid may choose among the alternatives which services are available based on cost-effectiveness. Any alternative services must be prior authorized.

004.02(E)(iii) SERVICE SPECIFIC CRITERIA. Services currently covered by the Department will be governed by each service specific chapter in NAC 471. Services not covered by the Department but defined in Section 1905(a) of the Social Security Act must meet the conditions of items (1) through (4) above. Criteria and requirements for certain services are outlined in this chapter.

004.02(F) HEALTH CHECK SPECIAL SERVICES. The following services are covered to prevent, correct, or ameliorate a disease or condition identified during a screening examination. These services are considered part of the HEALTH CHECK benefit and are available to Nebraska Medicaid-eligible individuals under 21. Payment for special services is made according to the Nebraska Medicaid Practitioner Fee Schedule unless included as part of a capitation plan. Instructions for billing must be included with the written approval. The Department may also withdraw a provider's approval by written notification to the provider if the provider no longer meets the following identified requirements.

004.02(F)(i) MEDICAL NUTRITION THERAPY. This service involves medically necessary counseling provided by a licensed medical nutritional therapist. The child's condition must indicate that a nutritional problem or a condition of such severity exists that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. This service is covered when the client is referred by a physician or nurse practitioner. Therapies must be in accordance with currently accepted dietary and nutritional protocols. A referral must be made to the Special Supplemental Food Program for Women, Infants, and Children (WIC) for ongoing nutritional information for children under five, or for lactating, postpartum, or pregnant women.

004.02(F)(ii) RISK REDUCTION SERVICES. Risk reduction services include:

(a) Family home visitation for risk assessment and risk reduction services;
(b) Health education and infant-child care and parenting session or breast-feeding instruction sessions;
(c) Early pregnancy sessions;
(d) Prepared childbirth session or comparable cesarean birth sessions; and
(e) Prepared childbirth refresher series.

004.02(F)(ii)(1) PREPARED CHILDBIRTH SESSIONS. The basic six to eight-week series of childbirth sessions, early pregnancy sessions, refresher sessions, cesarean birth sessions, breast-feeding session, and infant care sessions are covered when provided by licensed and Nebraska Medicaid-enrolled practitioners approved by the Department. The services are covered when a comparable community service is not readily available at no cost.

004.02(F)(ii)(2) PEDIATRIC PRENATAL VISIT. Pediatric prenatal visits are covered if scheduled in the last trimester of the pregnancy. The following items must be completed as a part of pediatric prenatal visit:

(a) Gather medical information, give information, answer questions, and initiate a continuing relationship in the best interest of the child;
(b) Discuss the benefits of early and regular health care, of appointment-keeping, and utilizing the most appropriate place of service;
(c) Include a maternal and family health history and related data gathering;
(d) Prepare parent(s) for hospital birth information on breast-feeding vs. bottle feeding, information on infant care, and information on parenting classes;
(e) Preparation parent(s) for potential changes in family and sibling relationships with birth;
(f) Provide information on effects of drugs and medications on pregnancy and nursing infants;
(g) Discuss preparation for home care and home safety; and
(h) Provide information on well baby care, information on choosing child care, and office philosophy and practices.

004.02(F)(iii) WELL CHILD CLUSTER VISIT. The cluster visit is a well child visit in a group setting with parent-child pairs of similar age offering the opportunity for the provision of extended physician-parent and child time with a focus on psychosocial aspects as well as physical aspects of well child care. Cluster visits are covered for infants and children, according to the American Academy of Pediatric schedule for examinations. The cluster visit must include a complete HEALTH CHECK examination. The parent may opt for this service instead of the individual visit for the parent(s).

004.02(G) LACTATION COUNSELING. Lactation counseling services are covered for children in the post-partum period and their mothers who need help with breastfeeding. Services may be sought for difficulties such as inadequate milk supply, poor milk extraction, poor weight gain, nipple and breast pain, breast infections, and engorgement. Lactation counseling services are covered for children age birth through ninety days postpartum or ninety days corrected for gestational age; however, it may be available after 90 days postpartum when medically necessary. There is a limit of five counseling sessions per child, and each session may last up to ninety minutes. Comprehensive lactation counseling must include the following:

(i) A face-to-face encounter with the mother and child lasting a minimum of thirty minutes;
(ii) Comprehensive maternal, infant and feeding assessment related to lactation;
(iii) Interventions at a minimum:
    (1) Observation of mother and child during breastfeeding;
    (2) Instruction in positioning techniques and proper latching to the breast; and
    (3) Counseling in nutritive suckling and swallowing, milk production and release, frequency of feedings and feeding cues, expression of milk and use of pump if indicated, assessment of infant nourishment and reasons to contact a health care provider;
(iv) Information on community supports such as Women, Infant and Children (WIC); and

(v) Evaluation of outcomes from interventions.

005. BILLING AND PAYMENT FOR HEALTH CHECK SERVICES.

005.01 BILLING.

005.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event that individual billing requirements in 471 NAC 3 conflict with billing requirements outlined in this 471 NAC 33, the individual billing requirements in 471 NAC 33 will govern.

005.01(B) SPECIFIC BILLING REQUIREMENTS. Providers must bill the Department using Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) for HEALTH CHECK exams, HEALTH CHECK-associated services, and other comparable exams. The physician or the physician's authorized agent must submit the physician's usual and customary charge for each procedure code listed on or in the claim.

005.01(B)(i) PROCEDURE CODES. Physicians must use Healthcare Common Procedure Coding System (HCPCS) procedure codes when submitting claims or encounter data to the Department. Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule.

005.01(B)(ii) VACCINE FOR CHILDREN PROGRAM (VFC) PROGRAM. When a physician uses federal-purchased vaccine for immunizations, the physician must bill the Department only for the administration. The physician must use the modifier "SL" with the vaccine code when billing for the administration. Billed charges for the administration of Vaccine for Children Program (VFC) vaccines cannot exceed the state maximum as determined by the federal Vaccine for Children Program (VFC) program. Contact the Nebraska Vaccine for Children Program (VFC) program with questions regarding the Nebraska maximum.

005.02 PAYMENT.

005.02(A) GENERAL PAYMENT REQUIREMENTS. The Department will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 3. In the event that individual payment regulations in 471 NAC 3 conflict with payment regulations outlined in this 471 NAC 33, the individual payment regulations in 471 NAC 33 will govern.

005.02(B) SPECIFIC PAYMENT REQUIREMENTS. The Department pays for covered HEALTH CHECK services, except for clinical laboratory services or individuals enrolled in managed care, at the lower of:

(1) The provider's submitted charge; or

(2) The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service.

005.02(B)(i) VACCINE FOR CHILDREN PROGRAM (VFC) PROGRAM. The Department reimburses for the administration of Vaccine for Children Program (VFC) vaccine according to the Nebraska Medicaid Practitioner Fee Schedule.

005.02(B)(ii) SPECIAL SERVICES. Payment for special services is made according to the Nebraska Medicaid Practitioner Fee Schedule unless included as part of a capitation plan. The Department may also withdraw a provider's approval by written notification to the provider if the provider no longer meets the following identified requirements.

005.02(B)(iii) ENVIRONMENTAL INVESTIGATION FOR LEAD CONTAMINATION. Payment will be made under an interagency contract with local or state health departments utilizing a certified lead inspector at a negotiated rate that includes the initial environmental investigation and a follow-up visit, if needed.