Table of Contents

State/Territory Name: NE

State Plan Amendment (SPA) #: 16-0011

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

November 15, 2016

Calder Lynch, Medicaid Director
Department of Health & Human Services
Division of Medicaid and Long-Term Care
301 Centennial Mall South, 5th Floor
PO Box 95026
Lincoln, NE 68509-5026

Dear Mr. Lynch:

On August 11, 2016, the Centers for Medicare & Medicaid Services (CMS) received Nebraska's State Plan Amendment (SPA) transmittal #16-0011. This SPA implements a 2% provider rate increase for SFY 2017.

SPA #16-0011 was approved November 8, 2016, with an effective date of July 1, 2016, as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Nebraska State Plan.

If you have any questions regarding this amendment, please contact Barbara Cotterman or Kevin Slaven at (816) 426-5925.

Sincerely, 11/15/2016

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Signed by: James G. Scott -A

Enclosure

cc:
Nancy Keller
Rosalind Sipe
DHHS Nebraska

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

November 21, 2016

Calder Lynch, Medicaid Director
Department of Health & Human Services
Division of Medicaid and Long-Term Care
301 Centennial Mall South, 5th Floor
PO Box 95026
Lincoln, NE 68509-5026

RE: NE 16-0006

Dear Mr. Lynch:

On May 15, 2016 the Centers for Medicare & Medicaid Services (CMS) received Nebraska's State Plan Amendment (SPA) transmittal# 16-0006. CMS issued a companion letter to the approval of SPA 16-0006 in which we identified a number of issues that needed to be addressed in corresponding pages to those which were approved.

With the submission of NE 16-0011, Nebraska has addressed some of the issues identified in the companion letter mentioned above. We are reissuing this updated companion letter to NE 16-0006 to express CMS's intent to continue to work with Nebraska to resolve the remaining outstanding issues identified below:

Reimbursement Questions/Comments:

1. Attachment 4.19-B, Item 2a, Page 2 - Please clarify how the rate is established for Payment to Hospital-Affiliated Ambulatory Surgical Centers (HAASC) when the HAASC is a Medicare-participating Ambulatory Surgical Center.

2. Attachment 4.19-B, Item 2a, Page 2 - Please clarify how Diagnostic and Therapeutic Services are paid.

3. Attachment 4.19-B, Item 11a, Page 2 - Please provide a copy of the cost report used to develop rates and a step by step explanation of how costs are identified.

4. Attachment 4.19-B, Item 11b, Page 2 - Please provide a copy of the cost report used to develop rates and a step by step explanation of how costs are identified.

The state has 90 days from the date of the original companion letter, dated September 16, 2016, to address the issues described above. Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide any required technical assistance.

If you have any questions, please contact Kevin Slaven, of my staff, at (816) 426-5925 or Kevin.Slaven@cms.hhs.gov.

Sincerely, 11/21/2016

Megan K. Buck
Acting Associate Regional Administrator
for Medicaid and Children's Health Operations

Signed by: Megan K. Buck -A

cc:
Rocky Thompson
Kimberly McClintick

Revised Submission 10.24.16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

)R: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 16-0011

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $2,027,972.00
b. FFY 2017 ~~$6,083,917.00~~ $8,111,889.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment. 4.19-B: ~~Item 1a~~; Item 1, page 1-~~3~~; Item 2a, page 1, & 4; Item 2c, page 4; Item 4b, page 1 & 3; Item 5, page 1; Item 9, page 5; Item 13d, page 1a; Item 24a; Item 27

Attachment 4.19-B - Item 3, page1 & 2; Item 4b, page 2; Item 4c, page 1; Item 5, page 2; Item 6a, page 1; Item 6b, page 1; Item 6c, page 1; Item 7, page 1, Item 7c, page 1; Item 9, page 1; Item 10, page 1; Item 11a, page 1; Item 11b, page 1; Item 11c, page 1; Item 12b, Item 12c; Item 12d, Item 13b, page 1; Item 20, page 1; Item 21, page 1; Item 26.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment. 4.19-B: Item 1a; Item 1, page 1-3; Item 2a, page 1, & 4; Item 2c, page 4; Item 4b, page 1 & 3; Item 5, page 1; Item 9, page 5; Item 13d, page 1a; Item 24a; Item 27

Attachment 4.19-B - Item 3, page1 & 2; Item 4b, page 2; Item 4c, page 1; Item 5, page 2; Item 6a, page 1; Item 6b, page 1; Item 6c, page 1; Item 7, page 1, Item 7c, page 1; Item 9, page 1; Item 10, page 1; Item 11a, page 1; Item 11b, page 1; Item 11c, page 1; Item 12b, Item 12c; Item 12d, Item 13b, page 1; Item 20, page 1; Item 21, page 1; Item 26.

10. SUBJECT OF AMENDMENT:
Medicaid rate increase SFY 17

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Calder Lynch

14. TITLE:
Director, Division of Medicaid and Long-Term Care

15. DATE SUBMITTED:
August 11, 2016

16. RETURN TO:

Nancy Keller
Division of Medicaid & Long-Term Care
Nebraska Department of Health & Human Services
301 Centennial Mall South
Lincoln, NE 68509

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
August 11, 2016

18. DATE APPROVED:
November 8, 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
James G. Scott

22. TITLE: Associate Regional Administrator
for Medicaid and Children's Health Operations

23. REMARKS:

* Pen and ink changes per state requests dated 10.24.16, 11.3.16 and 11.4.16.

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Except for Clinical Laboratory services and Injectable Drugs, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

The fee schedule amounts for Clinical Laboratory services are based on 100% Medicare Clinical Laboratory Fee Schedule. The Department shall update the Clinical Laboratory fee schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

The fee schedule amounts for Injectables are based on 100% Medicare Drug fee schedule. The Department shall update the Injectables Fee Schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services. Injectable medications approved by the Medicaid Medical Director but not included on the Medicare Drug Fee Schedule will be reimbursed at the estimated acquisition cost (EAC) used to reimburse pharmacy claims.

The agency's fee schedule rate was set as of July 1, 2016 and is effective for services provided on or after that date.

Payment methods for each service are defined in Attachment 4.19-B, Methods and Standards for Establishing Payment Rates, as referenced below.

Service	**Attachment**	**Effective Date**
ANESTHESIA	ATTACHMENT 4.19-B Item 6d	July 1, 2016
PRTF SERVICES	ATTACHMENT 4.19-A Page 30	July 1, 2016
SECURE PSYCHIATRIC RESIDENTIAL REHABILITATION	ATTACHMENT 4.19-B Item 13d, Page 1a	July 1, 2016

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Outpatient Hospital and Emergency Room Services: For services provided on or after July 1, 2016, the Department pays for outpatient hospital and emergency services with a rate which is the product of:

1. Eighty percent (82%) of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form CMS-2552-89, Pub. 15-II, Worksheet C); multiplied by
2. The hospital's submitted charges on Form CMS-1450 (UB-04).

The effective date of the cost-to-charges percentage is the first day of the month following the Department's receipt of the cost report.

Providers shall bill outpatient hospital and emergency room services on Form CMS-1450 (UB-04) in a summary bill format. Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services based on the fee schedule determined by Medicare.

Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: Effective for cost reporting periods beginning after July 1, 2016, payment for outpatient services of a CAH is one hundred percent (100%) of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. Nebraska Medicaid will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory services, that were previously paid for under those methods. Payment for these and other outpatient services will be made at one hundred percent (100%) of the reasonable cost of providing the services. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility's provider number. To avoid any interruption of payment, Nebraska Medicaid will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OUTPATIENT HOSPITAL SERVICES

Nebraska Medicaid pays for covered psychiatric partial hospitalization services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of psychiatric partial hospitalization services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

The Department may issue revisions of the Nebraska Medicaid Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telehealth encounter) will be equal to what would have been paid without the use of telehealth. If a core service is provided via telehealth and the center/clinic is the distant site, the FQHC will be reimbursed at the PPS or the APM encounter rate (whichever was chosen at the time of the service). Non FQHC services provided via telehealth would not be eligible for PPS/APM payment. Non-FQHC services will be paid according to the Nebraska Medicaid Practitioners Fee Schedule.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The provider must be in compliance with the standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Telehealth services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at
http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OTHER LABORATORY AND X-RAY SERVICES

Anatomical Laboratory Services

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for anatomical laboratory services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Anatomical Laboratory Services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Clinical Diagnostic Laboratory Services

Clinical diagnostic laboratory services, including collection of laboratory specimens by venipuncture or catheterization, is paid based on the fee schedule determined by Medicare.

X-Ray Services

For dates of service on or after August 1, 1989, Nebraska Medicaid pays a claim for both the technical and professional components of x-ray services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year. Updates are adjusted based on the Medicare fee schedule.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Clinical Diagnostic Laboratory Services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

For EPSDT services provided on or after April 1, 1990, the following applies.

For services reimbursed under the Nebraska Medicaid Practitioner Fee Schedule, Nebraska Medicaid pays for EPSDT services (except for clinical diagnostic laboratory services) at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule).

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of substance abuse services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Medicaid reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Except for Clinical Laboratory services and Injectable Drugs, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

Other services covered as EPSDT follow-up services will be paid according to currently established payment methodologies, i.e., inpatient hospital treatment for substance abuse treatment services will be paid according to the methodology in Attachment 4.19-A.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rates for the comparable in-person service.

Payment for Telehealth Transmission costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

Medicaid reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission shall be in compliance with the quality standards for real time, two-way interactive audiovisual transmission as set forth in state regulations as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Other Licensed Practitioners: Licensed Alcohol and Drug Counselor (LADC)
Rehabilitation Services - 42 CFR 440.130(d): Day Treatment/Intensive Outpatient Service by Direct Care Staff; Community Treatment Aide; Professional Resource Family Care; Therapeutic Group Home; Multisystemic Therapy; and Functional Family Therapy

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of substance abuse services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at
http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

The Nebraska Medicaid fee schedule outlined above will be established using the following methodologies:

If a Medicare fee exists for a defined covered procedure code, then Nebraska will set the Nebraska Medicaid fee schedule for LADC at 95 percent of the licensed Master's level rate paid under Attachment 3.1A, Item 6d for any codes permitted under their scope of practice per Nebraska state law.

Where Medicare fees do not exist for a covered code, the fee schedule will be set using a market-based pricing methodology as described below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(30) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

The market-based pricing methodology will be composed of provider cost modeling for four key components: direct care salary expenses, employee related expenses, program indirect expenses and administrative expenses. The analysis includes national compensation studies for Nebraska to determine the appropriate wage or salary expense for the direct care worker providing each service based on the staffing requirements and roles and responsibilities of the worker, published information related to employee related expenses and other notable cost components and cost data and fees from similar State Medicaid programs. The following list outlines the major components of the cost model to be used in fee development:

(1) Staffing Assumptions and Staff Wages
(2) Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
(3) Program-Related Expenses (e.g., supplies)
(4) Provider Overhead Expenses
(5) Program Billable Units

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FAMILY PLANNING SERVICES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for family planning services and supplies for individuals of child-bearing age at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Family Planning Services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PHYSICIANS' SERVICES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for covered physicians' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule); or
   c. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).
3. Exception: The Director of the Division of Medicaid and Long-Term Care or designee may enter into an agreement for a negotiated rate with an out-of-state provider which will be based on a percentage of billed charges, not to exceed 100%, only when the Medical Director of the Division has determined that:
   a. The client requires specialized services that are not available in Nebraska; and
   b. No other source of the specialized service can be found.

The following is a listing of specialized physician services that have been previously rendered by out-of-state providers:

a. lung transplants; and
b. pediatric heart transplants.

Note: The above listing is not all-inclusive of the specialized physician services that will be reimbursed via negotiated rates in the future, as it is based on previous experience.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physicians' services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

Physicians and non-physician care providers are subject to a site-of-service payment adjustment. A site-of-service differential that reduces the fee schedule amount for specific CPT/HCPCS codes will be applied when the service is provided in the facility setting. Based on the Medicare differential, Nebraska Medicaid will reimburse specific CPT/HCPCS codes with adjusted rates based on the site-of-service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

SMOKING CESSATION

Smoking cessation services rendered via common procedural terminology (CPT) codes 99406 and 99407 are reimbursed on a fee schedule.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Smoking cessation, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PODIATRISTS' SERVICES

Nebraska Medicaid pays for covered podiatry services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount;
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Podiatrists' services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OPTOMETRISTS' SERVICES

Nebraska Medicaid pays for covered optometrists' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Optometrists' services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

CHIROPRACTORS' SERVICES

Nebraska Medicaid pays for covered chiropractors' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Chiropractor's services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

HOME HEALTH SERVICES

Medicaid pays for medically prescribed and Department- approved home health agency services provided by Medicare-certified home health agencies. The Department may request a cost report from any participating agency.

For dates of service on or after July 1, 1990, Medicaid pays for home health agency services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service.

The Nebraska Home Health Agency Fee Schedule is effective for July 1 through June 30 of each fiscal year.

The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
3. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Payment for supplies normally carried in the nursing bag and incidental to the nursing visit is included in the per visit rate. Medical supplies not normally carried in the nursing bag are provided by pharmacies or medical suppliers who bill Medicaid directly. Under extenuating circumstances, the home health agency may bill for a limited quantity of supplies.

Medicaid applies the following payment limitations:
Brief Services are performed by a home health or private-duty nursing service provider to complete the client's daily care in a duration of 15 minutes to two hours per visit, when medically necessary. The services may be divided into two or more trips.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Home Health Services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES FOR SUITABLE USE IN THE HOME

Nebraska Medicaid pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Medical Supplies, Equipment, and Applications, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

CLINIC SERVICES

Nebraska Medicaid pays for clinic services and outpatient mental health services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Clinic Services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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 schedule amounts for covered services provided by Medicaid enrolled licensed practitioners. This service is reimbursed via a daily rate.

Pediatric Feeding Disorder Clinic Outpatient Treatment: Reimbursement for Pediatric Feeding Disorder Clinic Outpatient Treatment for medically necessary services will be based on the appropriate fee schedule amount for a physician consultation. This service is reimbursed via an encounter rate.

An encounter means a face-to-face visit between a Medicaid-eligible patient and a physician, psychologist, speech therapist, physical therapist, or dietician during which services are rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of pediatric feeding disorder services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

DENTAL SERVICES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for dental services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee - Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Dental Services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PHYSICAL THERAPY

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for physical therapy services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Physical Therapy, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OCCUPATIONAL THERAPY

Nebraska Medicaid pays for occupational therapy services provided by independent providers at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule - as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" – by report or "RNE" - rate not established in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Occupational Therapy, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS (PROVIDED BY OR UNDER THE SUPERVISION OF A SPEECH PATHOLOGIST OR AUDIOLOGIST)

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for services for individual with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist) at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Services for Individuals with Speech, Hearing, and Language Disorders, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

DENTURES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for dentures at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Dentures, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PROSTHETIC DEVICES

Nebraska Medicaid pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CRT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Prosthetic Devices, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

EYEGLASSES

Nebraska Medicaid pays for covered eyeglasses at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" by report or "RNE" rate not established in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Eyeglasses, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SCREENING SERVICES

Nebraska Medicaid pay for covered screening services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:
1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable among for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Screening Services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SECURE PSYCHIATRIC RESIDENTIAL REHABILITATION

Medicaid has researched the cost of an existing similar service to develop a comparable rate. Costs for treatment and rehabilitation services are contained in the Medicaid rate. The rate does not include room and board. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Secure Psychiatric Residential Rehabilitation Services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

The State Medicaid agency will have an agreement with each entity receiving payment under Secure Psychiatric Residential Rehabilitation services that will require that the entity furnish to the Medicaid agency on an annual basis the following:

- Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate,
- Cost information by practitioner type and by type of service actually delivered within the services unit,
- Provider's annual utilization data and cost information shall support that the required type, quantity and intensity of treatment services are delivered to meet the medical needs of the clients served. Medicaid Agency or its designee may further evaluate through on site or post pay review of the treatment plans and the specific services delivered as necessary to assure compliance.

COMMUNITY SUPPORT SERVICES

Community Support Services shall be reimbursed on a direct service by service basis and billed in 15 minute increments up to a maximum of 144 units per 180 days.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of community support services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

This rate will be the same for quasi-governmental and private providers of community support service.

The rate includes all indirect services and collateral contacts that are medically necessary rehabilitative related interventions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

EXTENDED SERVICES TO PREGNANT WOMEN

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for extended services to pregnant women at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:
1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year, and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Extended services to pregnant women, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

AMBULATORY PRENATAL CARE FOR PREGNANT WOMEN FURNISHED DURING A PRESUMPTIVE ELIGIBILITY PERIOD

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a Medicaid-enrolled provider at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

TRANSPORTATION SERVICES

For dates of service on or after May 1, 2011, Medicaid pays for emergency and non-emergency medical transportation services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
    a. The unit value multiplied by the conversion factor;
    b. The invoice cost (indicated as "IC" in the fee schedule);
    c. The maximum allowable dollar amount; or
    d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of non-emergency transportation services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PERSONAL CARE AIDE SERVICES

For services provided on or after July 1, 1998. Nebraska Medicaid pays for personal care aide services at the lower of:

1. The provider's submitted charge: or
2. The allowable amount for that procedure code the Nebraska Medicaid Care Aide Fee Schedule.

The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Establish an initial allowable amount for a new procedure: or
3. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is not appropriate.

Personal Assistance Services will be reimbursed at rates established and published by Nebraska Health and Human Services. Rates are based on experience or training of the Personal Assistance provider.

For purpose of establishing the provider payment rate. Nebraska Medicaid considers a provider of personal assistance services to be "specialized" the provider meets one of the following criteria and presents a copy of the certificate or license to the worker. The provider must:

1. Have successfully completed the American Red Cross Home-Bound Care Course or a basic aide training course that has been approved by the Nebraska Health and Human Services System;
2. Have passed the Nurse Aide Equivalency test;
3. Be a licensed R.N. or L.P.N: or
4. Have a total of 4160 hours of experience as a personal assistance service provider.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Personal Care Aide Services, the agency's rates were set as of July 1, 2016, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FREESTANDING BIRTH CENTER SERVICES

Nebraska Medicaid providers of birthing center services are reimbursed based on a fee schedule as follows:

a. Payment for birthing center services provided by a participating, licensed birthing center is limited to the allowable rates established by Nebraska Medicaid.
b. The fee schedule established by Nebraska Medicaid is based upon a review of Medicaid fees paid by other states;
c. The birthing center and the birth attendant must bill separately for the services provided by each. The birthing center may bill only for facility services outlined elsewhere in this state plan.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Freestanding Birthing Center Services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/medicaid/Pages/med_practitioner_fee_schedule.aspx.