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State/Territory Name: NE

State Plan Amendment (SPA) NE: 24-0010

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

November 26, 2024

Matthew Ahem, Interim Director
Division of Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

RE: TN NE-24-0010

Dear Interim Director Ahem:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Nebraska state plan amendment (SPA) to Attachment 4.19-B NE 24-0010, which was submitted to CMS on September 04, 2024. This plan amendment increases payment rates for dental services, pharmacy dispensing fees, lactation counseling services, and personal assistance services (PAS).

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 01, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact LaJoshica (Josh) Smith at 214-767-6453 or via email at lajoshica.smith@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0010

2. STATE: NE

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT ☒ XIX ☐ XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 129,539
b. FFY 2025 $ 508,605

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att. 4.19-B, Item 1, Pg 1; Item 2a, Pgs 1-4; Item 2c, Pg 4; Item 3, Pgs 1&2; Item 4b, Pgs 1-3; Item 4c, Pg 1; Item 5, Pgs 1&2; Item 6a, Pg 1; Item 6b, Pg 1; Item 6c, Pg 1; Item 7, Pg 1; Item 7, Pg 1a; Item 7c, Pg 1; Item 9, Pgs 1&5; Item 10, Pg 1; Item 11a, Pg 1; Item 11b, Pg 1; Item 11c, Pg 1; Item 12a, Pg 1 of 2; Item 12b; Item 12c; Item 12d; Item 13b, Pg 1; Item 13c, Pg 1; Item 13d, Pg 1a; Item 13d, Pg 1b; Item 20, Pg 1; Item 21, Pg 1; Item 26; and Item 27

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att. 4.19-B, Item 1, Pg 1; Item 2a, Pgs 1-4; Item 2c, Pg 4; Item 3, Pgs 1&2; Item 4b, Pgs 1-3; Item 4c, Pg 1; Item 5, Pgs 1&2; Item 6a, Pg 1; Item 6b, Pg 1; Item 6c, Pg 1; Item 7, Pg 1; Item 7, Pg 1a; Item 7c, Pg 1; Item 9, Pgs 1&5; Item 10, Pg 1; Item 11a, Pg 1; Item 11b, Pg 1; Item 11c, Pg 1; Item 12a, Pg 1 of 2; Item 12b; Item 12c; Item 12d; Item 13b, Pg 1; Item 13c, Pg 1; Item 13d, Pg 1a; Item 13d, Pg 1b; Item 20, Pg 1; Item 21, Pg 1; Item 26; and Item 27

9. SUBJECT OF AMENDMENT
SFY25 Outpatient and Professional Provider Rates

10. 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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Matthew Ahern

13. TITLE
Interim Director, Division of Medicaid & Long-Term Care

14. DATE SUBMITTED
September 4, 2024

15. RETURN TO
Dawn Kastens
Division of Medicaid & Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

FOR CMS USE ONLY

16. DATE RECEIVED
09/04/2024

17. DATE APPROVED
November 26, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
07/01/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

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, 2024, and are effective for services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program.

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, 2024 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, 2024
PRTF	ATTACHMENT 4.19-A Page 30	July 1, 2024

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, 2024, the Department pays for outpatient hospital and emergency services with a rate which is the product of:

1. Ninety percent (93%) 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

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

1. The patient is evaluated or treated for a medical emergency, accident, or injury;
2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as charges and included in the inpatient per diem); or
3. The patient is referred by a physician or licensed nurse practitioner such as for allergy shots or when traveling (a written referral by the physician or licensed nurse practitioner must be attached to the claim).

The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency and bill accordingly.
When the facility or the Department determine services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of the applicable ratio of cost-to-charges. All other Medicaid allowable charges incurred in this type visit will be paid at ninety-three percent (93%) of the ratio of cost-to-charges.

Diagnostic and Therapeutic Services: The payment rate for diagnostic and therapeutic services includes payment for services required to provide the service. Extra charges, such as stat fees, call-back fees, specimen handling fees, etc., are considered administrative expenses and are included in the payment rate.

Payment to a New Hospital for Outpatient Services: Payment to a new hospital (an operational facility) will be made at the statewide average ratio of cost to charges for Nebraska hospitals as of July 1 of that year as determined by the Department. This payment is retrospective for the first reporting period for the facility. This ratio will be used until the Department receives the hospital's initial cost report.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Upon the Department's receipt of the hospital's initial Medicare cost report, the Department shall no longer consider the hospital to be a "new hospital" for payment of outpatient services. The Department shall determine the ratio of cost to charges from the initial cost report and shall use that ratio to prospectively pay for outpatient services.

Payment to An Out-of-State Hospital for Outpatient Services: Payment to an out-of-state hospital for outpatient services will be made based on the statewide average ratio.

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 the 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 audio-visual 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

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 Mental Health and Substance Use 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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, 2024 and is effective for psychiatric partial hospitalization services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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 Physician and Mental Health and Substance Use Fee Schedule, as authorized elsewhere in the plan.

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. Telehealth transmission cost and originating site fee are found on the Physician and Mental Health and Substance Use Fee Schedules, as authorized elsewhere in the plan.

The agency's fee schedule rate was set as of July 1, 2024 and is effective for telehealth transmission cost and originating site services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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 Physician or Clinical Laboratory 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

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. The agency's rates were set as of July 1, 2024, and are effective for anatomical laboratory services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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.

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.

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 Physician 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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.

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. The agency’s rates were set as of July 1, 2024, and are effective for radiology services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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 Mental Health and Substance Use 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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 use services. The agency's fee schedule rate was set as of July 1, 2024 and is effective for EPSDT substance use services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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, 2024, and are effective for EPSDT services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

Other services covered as EPSDT follow-up services will be paid according to currently established payment methodologies, i.e., inpatient hospital treatment for substance use 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; Functional Family Therapy; and Peer Support.

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 use services. The agency's fee schedule rate was set as of July 1, 2024, and is effective for mental health and substance use services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

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 Physician 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

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. The agency's rates were set as of July 1, 2024, and are effective for family planning services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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 Physician 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.
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, 2024 and is effective for physician services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

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. Teleheath transmission cost and originating site fee are found on the Physician and Mental Health and Substance Use Fee Schedules, as authorized elsewhere in the plan.

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. The agency's rates were set as of July 1, 2024, and are effective for smoking cessation services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

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 Podiatry 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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. The agency's rates were set as of July 1, 2024, and are effective for podiatrists' services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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 Vision 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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. The agency's rates were set as of July 1, 2024, and are effective for optometrists' services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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CHIROPRACTIC SERVICES

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

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Chiropractic Fee Schedule in effect for that date of service.

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. The agency's rates were set as of July 1, 2024, and are effective for chiropractic services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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HOME HEALTH SERVICES

Nebraska 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.

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.

Nebraska 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. The agency's rates were set as of July 1, 2024, and are effective for home health services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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HOME HEALTH SERVICES

A nurse practitioner, physician assistant, or clinical nurse specialist can order home health services and certify the home health agency's plan of care. Extended Services are performed by a home health or private-duty nursing service provider when the client's needs cannot be appropriately met within the Brief Service limitation of two hours or less.

Medicaid applies the following payment limitations to nursing services (RN and LPN) for adults age 21 and older:

a. Per diem reimbursement for nursing services for the care of ventilator-dependent clients are paid at the lower of:
   1. The provider's submitted charge;
   2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service; or
   3. The average ventilator-dependent per diem of all Nebraska nursing facilities which are providing that service. This average per diem shall be computed using nursing facility's ventilator rates which are effective July 1 of each year, and are applicable for that state fiscal year period.

b. Per diem reimbursement for all other in-home nursing services are paid at the lower of:
   1. The provider's submitted charge;
   2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service; or
   3. The Extensive Services 2 case-mix reimbursement level. This average shall be computed using the Extensive Services 2 case-mix nursing facility rates which are effective July 1 of each year, and applicable for that state fiscal year period.

Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30 day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.) 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. The agency's rates were set as of July 1, 2024, and are effective for home health services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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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 DMEPOS 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.
3. For DMEPOS items associated with Section 1903(i)(27) of the Social Security Act, amended by Section 5002 of the 21 Century Cures Act, and identified by the Centers of Medicare and Medicaid Services (CMS) as covered by Medicare, Medicaid will pay the lower of the following: (1) The Medicare DMEPOS fee schedule rate for Nebraska geographic, non-rural areas, set as of January 1 of each year, which will be reviewed on a quarterly basis and updated as Medicare updates the fee schedule; (2) the Medicare competitive bidding program rate for the specific item of DME, or (3) the provider's billed charges.

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. The agency's rates were set as of July 1, 2024, and are effective for medical supplies, equipment, and applications services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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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 Mental Health and Substance Use 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Mental Health and Substance Use Fee Schedule is effective July 1 through June 30 of each year.

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. The agency's rates were set as of July 1, 2024, and are effective for clinic services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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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, 2024 and is effective for pediatric feeding disorder services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Pediatric Feeding Clinics' fee schedule for the specific program and year.

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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 Dental 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

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. The agency's rates were set as of July 1, 2024 and are effective for dental services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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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 Physical Therapy and Occupational Therapy 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

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. The agency's rates were set as of July 1, 2024 and are effective for physical therapy services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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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 Physical Therapy and Occupational Therapy 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

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. The agency's rates were set as of July 1, 2024 and are effective for occupational therapy services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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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 Speech Pathology and Audiology 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of Medicare rate, the rate is determined as the average of available rates from other states.

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

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. The agency's rates were set as of July 1, 2024 and are effective for services for individuals with speech, hearing, and language disorders on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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Professional Dispensing Fees

Professional Dispensing Fee: A professional dispensing fee of $10.38 shall be assigned to each claim payment based on the lesser of methodology described below.

PRESCRIBED DRUGS (Continued)

Cost Limitations: The Nebraska Medicaid Drug Program is required to reimburse ingredient cost for covered outpatient legend and non-legend drugs at the lowest of:

Brand Drugs

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

The FUL or SMAC limitations will not apply in any case where the prescribing physician certifies that a specific brand is medically necessary. In these cases, the usual and customary charge or NADAC will be the maximum allowable cost.

Generic Drugs

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

Backup Ingredient Cost Benchmark

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

Specialty Drugs

Specialty drugs shall be reimbursed at NADAC plus the established professional dispensing fee. If NADAC is not available, then the Backup Ingredient Cost Benchmark will apply.

340B Drug Pricing Program

Covered legend and non-legend drugs, including specialty drugs, purchased through the Federal

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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 Dental 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

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. The agency's rates were set as of July 1, 2024 and are effective for denture services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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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 DMEPOS 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.
3. For DMEPOS items associated with Section 1903(i)(27) of the Social Security Act, amended by Section 5002 of the 21 Century Cures Act, and identified by the Centers of Medicare and Medicaid Services (CMS) as covered by Medicare, Medicaid will pay the lower of the following: (1) The Medicare DMEPOS fee schedule rate for Nebraska geographic, non-rural areas, set as of January 1 of each year, which will be reviewed on a quarterly basis and updated as Medicare updates the fee schedule; (2) the Medicare competitive bidding program rate for the specific item of DME, or (3) the provider's billed charges.

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. The agency’s rates were set as of July 1, 2024 and are effective for prosthetic device services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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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 Vision 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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. The agency's rates were set as of July 1, 2024 and are effective for eyeglass services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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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 Physician 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

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. The agency's rates were set as of July 1, 2024 and are effective for screening services on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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PREVENTIVE SERVICES

MEDICAL NUTRITION THERAPY/LACTATION COUNSELING SERVICES

Nebraska Medicaid pays for Medical Nutrition Therapy/ Lactation Counseling services at the lower of:

1. The provider's submitted charge; or
2. The maximum allowable fee established by the Department.

Except as otherwise noted in the plan, state – developed fee schedule rates are the same for both governmental and private providers of Medical Nutrition Therapy/Lactation Counseling Services. The agency's fee schedule rate for nutritional services was set as of July 1, 2017 and is effective for services provided on or after that date. All rates are published https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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.

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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, ~~2023~~ 2024 and is effective for secure psychiatric residential rehabilitation services provided on or after that date. All rates are published at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

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, 2024 and is effective for community support services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

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.

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PEER SUPPORT

Peer Support shall be reimbursed on a direct service by service basis and billed in 15 minute increments.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Peer Support services. The agency's Mental Health and Substance Use fee schedule rate for Peer Support will be set as of July 1, 2024 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/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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

OPIOID TREATMENT PROGRAM (OTP)

When services 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. The agency's OTP rates on the Mental Health and Substance Use fee schedule is updated as of July 1, 2024, and will be effective for services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

Effective for dates 10/1/2020 to 09/30/2025, services in this program are reimbursed per Supplement 2 to Attachment 4.19-B, page 1.

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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 Physician 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

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. The agency's rates were set as of July 1, 2024 and are effective for extended services to pregnant women on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

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 Ambulatory Surgical Center and Physician 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). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

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

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. The agency's rates were set as of July 1, 2024 and are effective for ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period on or after that date. All rates are published at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the fee schedule for the specific program and year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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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.

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. The agency's rates were set as of July 1, 2024 and are effective for personal care aide services provided on or after that date. All rates are published on the agency's website at: http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Personal Assistance fee schedule for the specific program and year.

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, 2024 and is effective for freestanding birthing center services provided on or after that date. All rates are published on the agency's website at http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx. From the landing page, scroll down to the Free Standing Birth Centers' fee schedule for the specific program and year.