

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, 2012, the Department pays for outpatient hospital and emergency services with a rate which is the product of:

1. Seventy four percent (74%) 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 ninety nine percent (99%) of 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, 2012, payment for outpatient services of a CAH is ninety nine percent (99%) 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. NMAP will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory or radiology services, that were previously paid for under those methods. Payment for these and other outpatient services will be made in at ninety nine percent (99%) 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, NMAP will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

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Payment to Hospital-Affiliated Ambulatory Surgical Centers: The Department pays for services provided in an HAASC according to Payment for Outpatient Hospital and Emergency Room Services, unless the HAASC is a Medicare-participating ambulatory surgical center (ASC). If the HAASC is a Medicare-participating ASC, payment is made at the rate established by Medicaid for the appropriate group of procedures.

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 (see definition of medical emergency in NAC 10-001.02);
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 such as for allergy shots or when traveling (a written referral by the physician 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 seventy four percent (74%) 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: See the definition of a new operational facility in 471 NAC 10-010.03A. Payment to a new hospital (a operational facility) will be made at seventy four percent (74%) of 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. The Department shall cost-settle claims for Medicaid-covered services which are paid by the Department using seventy four percent (74%) of the statewide average ratio of cost to charges. The cost settlement will be the lower of cost or charges as reflected on the hospital's cost report (i.e., the Department's payment must not exceed the upper limit of the provider's charges for services).

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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. (For a complete description of payment for outpatient services, see 471 NAC 10-010.06 ff.)

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 of cost to charges times seventy four percent (74%) for all Nebraska hospitals for that fiscal year as of July 1 of that 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 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.

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