NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

GUIDANCE DOCUMENT

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Neb. Rev. Stat. § 84-901.03

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DEPT. OF HEALTH AND HUMAN SERVICES

Indian Health Services (IHS) and Tribal 638 Provider Bulletin

Eligible Providers / Provider Requirements

To participate in Nebraska Medicaid, IHS and Tribal 638 facilities need to follow all applicable participation requirements outlined in 471 NAC 2 and 3. If the requirements outlined in 471 NAC 2 and 3 differ from those in 471 NAC 11, IHS and Tribal 638 providers should follow the requirements outlined in 471 NAC 11. Nebraska Medicaid accepts IHS and Tribal 638 facilities as Medicaid providers on the same basis as other qualified providers.

To receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) **must** be enrolled with Nebraska Medicaid.

Provider Type	Licensure Requirements
Individual IHS/Tribal Providers	Individual staff members and/or providers at IHS and Tribal 638 facilities must be licensed in another state if they are not licensed in Nebraska.
IHS/Tribal Facilities	Do not have to be licensed in Nebraska but must still meet all applicable standards for licensure by the Nebraska Department of Health and Human Services (DHHS), Division of Public Health.

All provider enrollment and agreement coordination are handled through Maximus. For more information on provider enrollment, visit Nebraska Medicaid's Provider Screening and Enrollment webpage.

Eligible Recipients

For detailed regulatory information about Nebraska Medicaid eligibility, including eligibility requirements, categories, and other related processes, see Title 477 of the Nebraska Administrative Code (NAC). For additional information about Medicaid applications and eligibility, visit Nebraska Medicaid's Medicaid Eligibility webpage.

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using the Nebraska Medicaid Eligibility System (NMES).

Cost Sharing Provisions

American Indians and Alaska Natives don't pay premiums, copayments, coinsurance, or deductibles under Medicaid.

This does not exclude American Indians and Alaska Natives from having to contribute toward and pay for share of cost programs, also known as spend-down programs. For such programs, expenses are paid as a part of meeting eligibility requirements.

Share of Cost Programs

Individuals with incomes too high for traditional Medicaid can sometimes qualify for Medicaid benefits through a share of cost program. Through these programs a beneficiary's medical expenses can be counted against their income, allowing them to qualify for benefits that they otherwise would not be eligible for.

In some cases, a spend-down (or share of cost) is required to be paid before an individual is eligible to receive Medicaid. Individuals who receive long-term care services are also required to pay a share of cost toward their monthly services.

Dual Eligibility

Individuals who are enrolled in both Medicare and Medicaid are known as dually eligible beneficiaries, and there are several different dual eligibility categories. A full dual is “someone with full Medicaid benefits” who is also enrolled in Medicare. For someone to have full Medicaid benefits, they must meet all eligibility requirements (e.g., income, citizenship, age, etc.) for a Medicaid category that provides medical benefits under the Medicaid state plan. In addition to these medical benefits under Medicaid, fully dual individuals are also enrolled in a Medicare Savings Program (MSP).

Medicare Savings Programs (MSPs) are programs that assist low-income Medicare beneficiaries with some or all of their Medicare Part A and/or B expenses. Enrollment in MSPs is dependent on the income and resource limits of individuals already enrolled in Medicare Part A and/or B. Enrollment in Medicaid categories is dependent on eligibility criteria defined in the Medicaid state plan. Some dually eligible beneficiaries may be enrolled in Medicare Part A and/or Part B, while not eligible for medical benefits under the Medicaid state plan. However, they can still be considered dually eligible due to enrollment in an MSP, wherein they qualify for Medicaid to help pay for Medicare premiums and out-of-pocket medical expenses (i.e., cost sharing: deductibles, coinsurance, and copayments).

For a comprehensive list of the federal Medicare Savings Programs, and how these overlap with full dual eligibility, see the following document from CMS: Dually Eligible Individuals – Categories.

Operationally in Nebraska, MLTC has its own terminology and categorization around dual eligibility which has been brought about by the Medicaid program’s structure and different systems limitations. All dual eligible beneficiaries in Nebraska would fall under MLTC’s Aged, Blind, and Disabled (ABD), or non-MAGI programs. Resource and income limits for these individuals can be found outlined in Appendix 477-000-012. For specific questions about the state’s categorization of dual eligibility groups, please reach out to the MLTC Tribal Liaison(s).

Application and Enrollment

To apply for benefits individuals can:

- Fill out an application online at iServe.
- Call one of the numbers below to apply over the phone or to request a paper application. Phone lines are open from 8:00 a.m. to 5:00 p.m. Monday through Friday.
    - (855) 632-7633
    - In Lincoln: (402) 473-7000
    - In Omaha: (402) 595-1178

  Visit a local DHHS office.

Beneficiaries already enrolled in Nebraska Medicaid can manage their benefits through ACCESSNebraska.

One Medicaid ID card is issued to all beneficiaries enrolled in Nebraska Medicaid, including those who are also enrolled in the Heritage Health managed care program. The card is **not** proof of eligibility but can be used by providers to verify beneficiary eligibility. Beneficiaries enrolled in managed care will also receive another separate managed care-specific member ID card in the welcome packet they receive from their managed care organization (MCO).

Covered Services

In addition to the limitation and requirements outlined in 471 NAC 11, IHS and Tribal 638 providers shall follow all applicable limitations outlined in 471 NAC 1 - 3, and all requirements outlined in each applicable service-specific chapter in Title 471 of the Nebraska Administrative Code (NAC).

Encounter Services

Qualifying encounters for services provided by IHS and Tribal 638 facilities are covered and reimbursed at the most current IHS encounter rate when medically necessary. This rate is published annually by IHS in the Federal Register. To qualify as an encounter, a service must be provided “face-to-face” between an approved healthcare provider and a Medicaid-eligible individual who can receive services at an IHS/Tribal 638 facility.

A practitioner visit covered under the scope of an encounter includes a “face-to-face” visit with any of the following qualifying healthcare providers:

- Physician, doctor of osteopathy, physician assistant, nurse practitioner, or certified nurse midwife;
- Dentist;
- Optometrist;
- Podiatrist;
- Chiropractor;
- Speech, audiology, physical or occupational therapist;
- Mental health provider such as a psychologist, psychiatrist, licensed mental health practitioner, certified drug and alcohol counselor, or a certified nurse practitioner providing psychotherapy or substance abuse counseling or other treatment with family and group therapy; or
- Pharmacist.

Encounter Restrictions

Encounter Scenario	Explanation
Diagnostic services provided during a patient's visit to the IHS/Tribal 638 facility – such as radiology services, laboratory tests, and blood draws	Diagnostic services are included in the encounter and are not separately billable. ***Exception:*** if one of these services are the only services provided to the beneficiary during their visit, the service could be billed as an encounter. For example, the facility could bill the encounter rate for a beneficiary who comes into the facility for lab work ordered by a qualifying provider.
Supplies used in conjunction with a visit – such as dressings, sutures, etc.	Included in the encounter and are not separately billable.
Medications used in conjunction with an encounter – such as an antibiotic injection	Included in the encounter and are not separately billable.
Prescribed drugs dispensed as a part of an inpatient encounter	Included in the encounter and are not separately billable.
Services provided by registered nurses	Included in the encounter and are not separately billable.
Services ordered by a qualifying provider but administered by a registered nurse	Could be billed as an encounter if those are the only services provided to the beneficiary during their visit.
Vaccines/vaccine administration	Included in the encounter and is not separately billable. ***Exception:*** if this is the only service provided to the beneficiary during their visit, the service could be billed as an encounter.
Pharmacy Encounter	One pharmacy encounter per day per beneficiary is reimbursable. For example, the first covered outpatient prescription drug submitted to Medicaid will pay the established encounter rate. Any subsequent outpatient pharmacy claims submitted for the same recipient with the same date of service will approve and pay $0. Nebraska Medicaid will audit claims for appropriate billing practices.
Professional services and facility fees	Both included in the reimbursement of an outpatient encounter and must not be separately billed to Nebraska Medicaid

Multiple Encounters

Visits with more than one health professional, and multiple visits with the same health professional, that take place during the same day within the IHS/Tribal facility constitute a single encounter.

Exceptions to this limit are described below. Distinctly different diagnoses are typically determined based upon the primary diagnosis code.

However, distinctly different services provided to the beneficiary by different qualifying provider types for the same primary diagnosis code may still be reimbursed as multiple encounters. For example, beneficiary visits to a licensed mental health practitioner and psychiatrist in the same day would be reimbursed as two separate encounters, since the scope and type of services provided by the two providers are distinctly different.

Multiple Encounter Exception	**Example**
When the patient is seen in the clinic, or by a heath professional, more than once in a 24-hour period for distinctly different diagnosis. Documentation must include unrelated diagnosis codes. **Note**: Distinctly different services provided to the beneficiary by different qualifying provider types for the same primary diagnosis code may still be reimbursed as multiple encounters. Documentation must include distinctly different service codes.	For example, a beneficiary visit to their primary care provider and a chiropractic visit on the same day would be reimbursed as two separate encounters since these services are distinctly different. **Note (Example)**: Beneficiary visits to a licensed mental health practitioner and psychiatrist on the same day would be reimbursed as two separate encounters, since the scope and type of services provided by the two providers are distinctly different.
When the patient must return to the clinic for an emergency or urgent care situation after the first encounter that requires additional diagnosis or treatment.	For example, if a beneficiary visits their primary care provider for a checkup in the morning and returns to the facility later in the afternoon to treat a broken limb, these two visits would be reimbursed as two separate encounters.
When a patient requires a pharmacy encounter in addition to a medical health professional or mental health encounter on the same day. Medicaid covers only one pharmacy encounter per day.	For example, a beneficiary visit to their primary care provider and a covered outpatient prescription that occurs on the same day would be reimbursed as two separate encounters.
When the patient is seen in the clinic by a mental health provider (see above) for a mental health encounter in addition to a medical health professional encounter on the same day.	For example, a beneficiary visit to their primary care provider and a visit with their psychiatrist that occur on the same day would be reimbursed as two separate encounters.

Telehealth Services

IHS and Tribal 638 facilities are allowed to bill and be reimbursed at the IHS encounter rate for services appropriately provided via telehealth. Providers must also meet all other applicable requirements around billing and reimbursement for telehealth services as required by Nebraska Medicaid and as outlined in state regulation. IHS and Tribal 638 facilities would also still need to meet the federal "four walls" requirement under 42 CFR § 440.90 by ensuring that either the provider or Medicaid beneficiary is present at the facility during the encounter.

Non-Encounter Services

Services rendered outside the office setting are not reimbursed at the encounter rate. Services that do not meet the criteria for an encounter or that are outside of the scope of an IHS/Tribal 638 Facility are not reimbursed at the encounter rate. Pharmacy services that are not provided by a designated tribal pharmacy or pharmacist are not reimbursed at the encounter rate. And services provided to non-American Indian or non-Alaska Native clients are not reimbursed at the encounter rate. Examples of non-encounter services include but are not limited to home health visits, ambulatory services, non-emergency medical transportation services, and nursing facility visits.

Out-of-State Services

Medicaid covers services rendered to beneficiaries when appropriately licensed Providers participating in the Nebraska Medicaid program administer services.

Non-Covered Services

Providers should refer to Section 3 of the Nebraska State Plan and Title 471 of the Nebraska Administrative Code to determine whether services are covered by Nebraska Medicaid.

Billing and Payment

Claims/Billing Instructions

IHS and Tribal 638 providers should comply with all billing requirements outlined in 471 NAC 3. If requirements outlined in 471 NAC 3 differ from those in 471 NAC 11, IHS and Tribal 638 providers should follow the requirements outlined in 471 NAC 11. IHS and Tribal 638 providers are required to follow all applicable billing instructions outlined in Appendix 471-000-62.

Facility Type	Claims Form
Hospital-based Facilities	Submit all claims for services provided to beneficiaries on the Form CMS-1450 For an example of the Form CMS-1450, see Appendix 471-000-51 For instructions and requirements regarding completing the Form CMS-1450, see Appendix 471-000-78

Non-hospital-based Providers	Submit all claims using the appropriate claim form or electronic format, as outlined in the Claim Submission Table in Appendix 477-000-49

All claims billed at the encounter rate must be billed using the 'T1015' code and 'SE' modifier. Additional service and diagnosis codes should also be included and billed under the T1015 code.

Reimbursement

Nebraska Medicaid will reimburse IHS and Tribal 638 providers for services provided in accordance with the applicable payment regulations outlined in 471 NAC 3. If payment regulations in 471 NAC 3 differ from those in 471 NAC Chapter 11, IHS and Tribal 638 providers should follow payment regulations outlined in 471 NAC 11.

IHS and Tribal 638 facilities will be paid at the most current IHS encounter rate for qualifying services (as outlined in 471 NAC 11) provided by the facility that are otherwise covered under the Nebraska Medicaid State Plan. All qualifying encounters, except for inpatient hospital encounters, are reimbursed at the outpatient encounter rate. Inpatient hospital encounters are reimbursed at the inpatient encounter rate.

To receive the inpatient hospital per diem rate, the IHS or Tribal 638 facility must:

- Be enrolled as a provider with Medicaid; and
- Appear on the IHS maintained listing of IHS-operated facilities and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

Encounter rate changes are effective the first day of the month following the Department's notice of the encounter rate posted by IHS in the Federal Register and will be applied retroactively to the federal effective date.

IHS/Tribal 638 providers may provide services outside of those that qualify as an encounter. Services covered under the Nebraska Medicaid State Plan, but not considered eligible for encounter reimbursement, should be billed on Form CMS-1500 using the appropriate HCPCS codes. These services will be paid according to the applicable Medicaid Provider Rates and Fee Schedules.

Documentation Requirements

Providers must keep medical and financial records that fully justify and disclose the extent of services provided and billed to Nebraska Medicaid in accordance with Provider Bulletin 21-10. Records must be retained for at least 6 years after the last date a claim was paid or denied. Medical records must clearly reflect when multiple encounters occurred and that these were medically necessary.

Timely Filing

Nebraska Medicaid must receive a provider's completed claim form within 6 months following the date the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by Nebraska Medicaid in certain circumstances.

Third-Party Liability

Medicaid recipients may have one or more additional sources of coverage for health services. Nebraska Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers, or pays after other liable third-party payers as applicable. Providers must pursue the availability of third-party payment sources and should reference state regulations and the CMS 'Coordination of Benefits and Third-Party Liability in Medicaid' instructions when applicable.

Third-Party Liability is defined in 471 NAC 3 as, "Any individual, entity, or program which is, or may be, contractually or legally liable to pay all or part of the cost of any medical service furnished to an individual." After receiving third-party liability payment for a claim, IHS/Tribal 638 providers may bill Medicaid or the MCOs to be reimbursed for the remaining amount up to the applicable encounter rate for qualifying encounter services, or the applicable fee schedule rate for non-qualifying encounters, provided to Medicaid-eligible beneficiaries (See 471 NAC 3.005.05).

Crossover Claims

In the case of fully dual eligible individuals (e.g. those enrolled in an MSP and eligible for Medicaid benefits), for services billed on Medicare crossover claims which also qualify as an encounter under Medicaid, Medicare reimburses the provider first, and Medicaid is required to pay for the remainder of the costs, up to the encounter rate (if Medicare's payment is less than the encounter rate amount).

However, for all other Medicare crossover claims for dually eligible beneficiaries who are not eligible for medical benefits under Medicaid, these claims would not qualify as an encounter under Medicaid, and thus would not be eligible for reimbursement at the IHS encounter rate. In these instances, Medicaid is only required to make a payment to providers on Medicare crossover claims if the Medicaid rate for the service provided exceeds the Medicare paid amount. When this is the case, Medicaid either pays the difference between the Medicare payment and the Medicaid rate or the Medicare cost sharing amount, whichever is less. This is also referred to as the "lesser-of" payment methodology. For more information about the Medicare crossover claims payment methodology in MLTC's state plan, see Supplement 1 to Attachment 4.19-B Pages 1-3.