Nebraska Medicaid Billing Instructions for Specialized Add-On Services (SAOS)

The instructions in this appendix apply when billing Nebraska Medicaid, also known as the Nebraska Medical Assistance Program (NMAP), for Medicaid-covered services provided to clients who are eligible for fee-for-service Medicaid. Medicaid regulations for **Specialized Add-On Services (SAOS) for Clients with Intellectual Disabilities or Related Conditions Residing in Nursing Facilities are covered in 471 NAC 12**.

CMS 1500 Claim Form Version

Nebraska Medicaid only accepts CMS 1500 claim form (version 02/12).

Third Party Resources: Claims for services provided to clients with third party resources (e.g., Medicare, private health/casualty insurance) must be billed to the third-party payer according to the payer's instructions. After the payment determination by the third-party payer is made, the provider may submit the claim to Nebraska Medicaid. A copy of the remittance advice, denial, explanation of benefits, or other documentation from the third-party resource must be submitted with the claim. For instructions on billing Medicare crossover claims, see 471-000-70.

Verifying Eligibility: Medicaid eligibility, managed care participation, and third-party resources may be verified from –

1. The client's permanent Nebraska Medicaid Identification Card or temporary Nebraska Medicaid Presumptive Eligibility Application. For explanation and examples, see 471-000-123;
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
3. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

CLAIM FORMATS

Electronic Claims: SAOS are billed to Nebraska Medicaid using the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

Paper Claims: SAOS are billed to Nebraska Medicaid on Form CMS-1500, "Health Insurance Claim Form." Instructions for completing Form CMS-1500 are in this appendix. The CMS-1500 claim form may be purchased from the U. S. Government Printing Office, Superintendent of Documents, Washington, D.C. 20402 or from private vendors.

MEDICAID CLAIM STATUS

The status of Nebraska Medicaid claims can be obtained by using the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277). For electronic transaction submission instructions, see 471-000-50.

Providers may also contact Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln) from 8:00 a.m. to 5:00 p.m. Monday through Friday.

REMITTANCE ADVICE AND REFUND REPORT

The Remittance Advice and Refund Requests report contains information on Medicaid processed claims (paid or denied), adjusted claims and requested refunds. A report is sent weekly when there is reportable activity. For detailed information see 471-000-85 in the provider handbook. See website for national code information: http://www.wpc-edi.com/codes/codes.asp

CMS-1500 FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims on Form CMS-1500, retain a duplicate copy and mail the ORIGINAL form to –

Medicaid Claims Unit
Division of Medicaid and Long-Term Care
Department of Health and Human Services
P. O. Box 95026
Lincoln, NE 68509-5026

Claim Adjustments and Refunds: See Title 471 Nebraska Medical Assistance Program Services Appendix 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Claim Example: See Title 471 Nebraska Medical Assistance Program Services Appendix 471-000-58 for an example of Form CMS-1500.

Claim Form Completion Instructions: The numbers listed below correspond to the numbers for the fields on the form. Completion of fields identified with an asterisk (*) is mandatory for claim acceptance. Information in fields without an asterisk is required for some aspect of claims processing/resolution. **Fields that are not listed are not needed for Nebraska Medicaid claims.**

*1a. INSURED'S I.D. NUMBER: Enter the Medicaid client's complete eleven-digit identification number (Example: 123456789-01).

*2. PATIENT'S NAME: Enter the full name (last name, first name, middle initial) of the person that received services.

3. PATIENT'S BIRTHDATE AND SEX: Enter the month, day, and year of birth of the person that received the services. Check the appropriate box (M or F).

9.–14 Fields 9-11 and 14 address third party resources other than Medicaid or Medicare. If there is no known insurance coverage, leave blank. If the client has insurance coverage other than Medicaid or Medicare, complete fields 9-11 and 14. A copy of the remittance advice,

explanation of benefits, denial, or other documentation is required and must be attached to the claim. Nebraska Medicaid must review all claims for possible third-party reimbursement. All third-party resources must be exhausted before Medicaid payment may be issued.

*15. OTHER DATE MM DD YY: Enter the initial date of treatment billed to Medicaid for the reported diagnosis. This will be the approval date for SAOS services on the prior authorization form, MLTC-78 in field 24.

*21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: The services reported on this claim form must be related to the diagnosis entered in this field. Enter the appropriate International Classification of Disease, Clinical Modification diagnosis codes for the following:

1. The diagnosis which includes the level of subluxation. This ICD 10 code must be listed as the PRIMARY diagnosis. This will be the diagnosis from the Level II PASRR.
2. The diagnosis on the PASRR, the Prior Authorization and the claim form MUST match.

The COMPLETE ICD 10 diagnosis code is required for the diagnosis identified on the Level II PASRR.

For claims being submitted on the CMS 1500 claim form (version 02-12) there are up to twelve diagnoses that may be entered in A-L. If there is more than one diagnosis, list the primary diagnosis first in 21A.

22. MEDICAID RESUBMISSION: Leave blank. For regulations regarding resubmittals or payment adjustment requests, see 471 NAC 3-000 and 471-000-99.

*23. PRIOR AUTHORIZATION NUMBER: Enter the Prior Authorization number from the approved Prior Authorization form for SAOS, MLTC-78.

*24. The six service lines in section 24 have been divided horizontally to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 services lines. Only six-line items can be entered in Filed 24. Do not print more than one line of information on each claim line. DO NOT LIST services for which there is no charge. Each line represents one session service.

*24A. DATE(S) OF SERVICE: In the unshaded area, enter the 8-digit numeric date of service rendered. Each procedure code/service billed requires a date. Each service must be listed on a separate line. The "From" date of service must be completed. The "To" date of service may be left blank.

*24B. PLACE OF SERVICE: In the unshaded area, enter the national two-digit place of service code that describes the location the service was rendered. National place of service codes is defined by the Centers for Medicare and Medicaid Services (CMS) and published on the CMS web site at http://www.cms.hhs.gov There are three possible place of service codes for SAOS:

31 Skilled Nursing Facility
32 Nursing Facility
99 Other Place of Service (A community setting)

*24D. PROCEDURES, SERVICES, OR SUPPLIES: In the unshaded area, enter the appropriate national CPT or HCPCS procedure code and, if applicable, procedure code modifier. Procedure codes for SAOS are listed on Nebraska Medicaid's public website at: https://dhhs.ne.gov/Medicaid%20Practitioner%20Fee%20Schedules/Specialized%20Add-On%20Services%20May%201,%202022.pdf

Only one procedure code can be billed per CMS 1500 claim form. If more than one service is being billed, each service's procedure code must be submitted on separate CMS 1500 claim forms.

Procedure Code Modifiers: On the claim form, enter modifier HI in the unshaded area under "MODIFIER" for each procedure code entered.

24E. DIAGNOSIS POINTER:
On the CMS 1500 claim form (version 02-12) list the reference letter of the primary diagnosis that is being treated from Field 21 (A-L). One diagnosis pointer may be entered per line.

*24F. $ CHARGES: Enter the rate for the procedure code. Each procedure code must be billed on a separate CMS 1500 claim form.

*24G. DAYS OR UNITS: Enter the number of units according to the Frequency for the service provided on the date of service. For example, if the Frequency for the service is "15 Minutes", one hour of the service on the date of service would be entered as four units.

*24J. RENDERING PROVIDER NPI: Enter the National Provider Identifier (NPI) of the rendering provider. The rendering provider will be the provider that worked with the client and provided the services.

25. FEDERAL TAX I.D. NUMBER: Effective 01/01/2012, this field is no longer required.

26. PATIENT'S ACCOUNT NO.: Optional. Any patient account information (numeric or alpha) may be entered in this field to enhance patient identification. This information will appear on the Medicaid Remittance Advice.

*28. TOTAL CHARGE: Enter the total of all charges (adding the amounts listed for each line for Field 24F). If more than one claim form is used to bill for services provided, EACH

claim form must be submitted with the Total Charge for the services listed on the claim form. DO NOT carry charges forward to another claim form.

*29. AMOUNT PAID: Enter any payments made, due, or obligated from other sources for services listed on this claim, unless the source is Medicare. Other sources may include health insurance, liability insurance, excess income, etc. A copy of the Medicare or insurance remittance advice, explanation of benefits, denial, or other documentation must be attached to each claim when submitting multiple claim forms. DO NOT enter previous Medicaid payments, Medicare payments, or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount) in this field.

30. Version (02/12) RSVD FOR NUCC USE – This field is utilized to show the difference between field 28 and 29 for share of cost if applicable.

*31. SIGNATURE OF PHYSICIAN OR SUPPLIER: The provider or authorized representative must SIGN and DATE the claim form. A signature stamp, computer generated, or typewritten signature will be accepted. The signature date must be on or after the dates of service listed on the form.

32. SERVICE FACILITY LOCATION INFORMATION: (if other than home or office): For mileage, enter the point of origin and final destination. For services provided to a client residing in a nursing facility or ICF/MR, enter the name of the facility.

*33. BILLING PROVIDER INFO & PHONE #: Enter the provider's name, address, nine-digit zip code, and phone number.

Effective 01/01/2012, enter the **nine-digit Zip Code (Zip+4)** of the Billing Provider, as reported to Nebraska Medicaid.

*33a. NPI #: Effective 01/01/2012, enter the **National Provider Identifier (NPI)** of the Billing Provider, as reported to Nebraska Medicaid.

*33b. Other ID #: Effective 01/01/2012, enter the 10-digit **Taxonomy Code** of the Billing Provider, as reported to Nebraska Medicaid.