471-000-81 Nebraska Medicaid Billing Instructions for Hospice Services

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 hospice services are covered in 471 NAC 36-000.

NOTE: Billing instructions for the following services are in separate appendices -

- Hospital services (see 471-000-52);
- Mental health/substance abuse services (see 471-000-64);
- Federally qualified health center services (see 471-000-76);
- Rural health clinic services (see 471-000-77); and
- Nursing facility services (see 471-000-82).

For a complete listing of billing instructions for all services, see 471-000-49.

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, 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

CLAIM FORMATS

Electronic Claims: Hospice services are billed to Nebraska Medicaid using the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.
Paper Claims: Hospice services are billed to Nebraska Medicaid on Form CMS-1450, "Health Insurance Claim Form.” Instructions for completing Form CMS-1450 are in this appendix.

Share of Cost Claims: Certain Medicaid clients are required to pay or obligate a portion of their medical costs due to excess income. These clients receive Form EA-160, “Record of Health Cost – Share of Cost – Medicaid Program” from the DHHS office to record services paid or obligated to providers. For an example and instructions on completing this form, see 471-000-79.

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.

CMS-1450 FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims on Form CMS-1450, 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 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Claim Example: See 471-000-51 for an example of Form CMS-1450.

Claim Form Completion Instructions: CMS-1450 (UB-04) completion requirements for Nebraska Medicaid are outlined below. The numbers listed correspond to the CMS-1450 form locators (FL) and are identified as required, situational or not used.

These instructions must be used with the complete CMS-1450 (UB-04) claim form completion instructions outlined in the National Uniform Billing Committee Data Specifications Manual. The National Uniform Billing Committee Data Specifications Manual is available through the Nebraska Hospital Association. Order information is at: http://www.nhanet.org/data_information/ub04.htm
HOSPICE BILLING INSTRUCTIONS

<table>
<thead>
<tr>
<th>FL</th>
<th>DATA ELEMENT DESCRIPTION</th>
<th>REQUIREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Provider Name, Address &amp; Telephone Number</td>
<td>Required</td>
</tr>
<tr>
<td>2.</td>
<td>Pay-to Name and Address</td>
<td>Situational</td>
</tr>
<tr>
<td>3a.</td>
<td>Patient Control Number</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>The patient control number will be reported on the Medicaid Remittance Advice.</td>
<td></td>
</tr>
<tr>
<td>3b.</td>
<td>Medical/Health Record Number</td>
<td>Situational</td>
</tr>
<tr>
<td>4.</td>
<td>Type of Bill</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Valid hospice bill types = 81X &amp; 82X</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Federal Tax Number</td>
<td>Required</td>
</tr>
<tr>
<td>6.</td>
<td>Statement Covers Period</td>
<td>Required</td>
</tr>
<tr>
<td>7.</td>
<td>Reserved for National Assignment by the NUBC</td>
<td>Not Used</td>
</tr>
<tr>
<td>8.</td>
<td>Patient Name/Identifier</td>
<td>Required</td>
</tr>
<tr>
<td>9.</td>
<td>Patient Address</td>
<td>Required</td>
</tr>
<tr>
<td>10.</td>
<td>Patient Birthdate</td>
<td>Required</td>
</tr>
<tr>
<td>11.</td>
<td>Patient Sex</td>
<td>Required</td>
</tr>
<tr>
<td>12.</td>
<td>Admission/Start of Care Date</td>
<td>Required</td>
</tr>
<tr>
<td>13.</td>
<td>Admission Hour</td>
<td>Not Used</td>
</tr>
<tr>
<td>14.</td>
<td>Priority (Type of Visit)</td>
<td>Not Used</td>
</tr>
<tr>
<td>15.</td>
<td>Source of Referral for Admission or Visit</td>
<td>Not Used</td>
</tr>
<tr>
<td>16.</td>
<td>Discharge Hour</td>
<td>Not Used</td>
</tr>
<tr>
<td>17.</td>
<td>Patient Discharge Status</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Must be sent on every Hospice claim and should reflect the status of the patient on the last day of the claim.</td>
<td></td>
</tr>
</tbody>
</table>
18-28. **Condition Codes**

Use if applicable.

29. **Accident State**

Not Used

30. **Reserved for National Assignment by the NUBC**

Not Used

31-34. **Occurrence Codes and Dates**

Occurrence Code 42 is required with the date of discharge when a client has been discharged from the Hospice agency. Traumatic diagnoses require an appropriate occurrence code.

35-36. **Occurrence Span Code and Dates**

Occurrence Span Code M2 is required with corresponding inpatient dates when billing Inpatient Respite Care and/or General Inpatient Care.

If an M2 occurrence date span is present the end date of the span will require the following billing combinations:

- If the patient status is death (values 20, 40, 41, or 42), the service line for the M2 end date must be billed as Inpatient Respite Care or General Inpatient Care.
- If the patient status code is 51 (Hospice – medical facility), the service line for the M2 end date must be billed as Inpatient Respite Care or General Inpatient Care.
- All other patient status codes require Routine Home Care to be billed on the service line for the M2 end date.

37. **Reserved for National Assignment by the NUBC**

Not Used

38. **Responsible Party Name and Address**

Situational

39-41. **Value Codes and Amounts**

Value code 61 is required with the CBSA/Special Wage Index Code number of the Medicaid client’s home when billing Routine Home Care and Continuous Home Care.

42. **Revenue Code**

- 651 - Routine Home Care
- 652 - Continuous Home Care
- 655 - Inpatient Respite Care
- 656 - General Inpatient Care

No other revenue codes accepted.

43. **Revenue Description**

Not Used
44. **HCPC Procedure Codes**
   - T2042 - Routine Home Care
   - T2043 - Continuous Home Care
   - T2044 - Inpatient Respite Care
   - T2045 - General Inpatient Care

   No other procedure codes accepted. Only one procedure code per day may be billed.

45. **Service Date**
   Required on all lines with claim date spans (FL6) greater than one calendar day. Each date must be billed on a separate line.

46. **Units of Service**
   Required
   One unit of service per line per day, except for T2043 (Continuous Home Care) which is billed hourly (minimum 8 hours up to a maximum of 24 hours).

47. **Total Charges (by Revenue Code Category)**
   Required
   Total charges must be greater than zero.
   Do not submit negative amounts.
   Each procedure code/line/date must have a separate charge.

48. **Non-Covered Charges**
   Not Used
   Do not bill charges that are not covered by Nebraska Medicaid Hospice Program.

49. **Reserved for National Assignment by the NUBC**
   Not Used

50. **Payer Name**
   Situational

51. **Health Plan Identification Number**
   Situational

52. **Release of Information Certification Indicator**
   Not Used

53. **Assignment of Benefits Certification Indicator**
   Not Used

54. **Prior Payments – Payers and Patient**
   Situational
   Enter any payments, made, due, or obligated from other sources for services listed on this claim unless the source is from 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, Medicaid co-payment amounts, Medicare payments, or the difference between the provider’s billed charge and the Medicaid allowable (provider “write-off” amount).

55. **Estimated Amount Due**
   Not Used
56. **National Provider Identifier – Billing Provider**
   Required
   Effective 01/01/2012, enter the National Provider Identifier (NPI) of the Billing Provider, as reported to Nebraska Medicaid.

57. **Other Provider Identifier**
   Not Used
   Effective 01/01/2012, this field is no longer required.

58. **Insured’s Name**
   Not Used

59. **Patient’s Relationship to Insured**
   Required

60. **Insured’s Unique Identification**
   Required
   Enter the Medicaid client’s complete eleven-digit identification number (example: 123456789-01).

61. **(Insured) Group Name**
   Situational
   Recommended when Nebraska Medicaid is the secondary payer

62. **Insurance Group Number**
   Situational
   Recommended when Nebraska Medicaid is the secondary payer.

63. **Treatment Authorization Code**
   Required

64. **Document Control Number (DCN)**
   Required
   Required when Type of Bill Frequency Code (FL04) indicates this claim is a replacement claim or void to a previously adjudicated claim.

65. **Employer Name of the Insured**
   Not Used

66. **Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**
   Required
   The qualifier denotes the version of International Classification of Diseases reported.

   The ICD Version Indicator will be used to distinguish if the submitted Code is an ICD-9 or an ICD-10 Code.

   Version ‘9’ indicates the Codes entered as ICD-9 Diagnosis or Surgical Procedure Code.

   Version ‘0’ indicates the Codes entered as ICD-10 Diagnosis or Surgical Procedure Code.

67. **Principal Diagnosis Code**
   Required
   Enter the International Classification of Diseases-Clinical Modification (ICD-CM) code describing the principal/primary diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care). The COMPLETE diagnosis code is required as defined in ICD-CM.

67A-Q. Other Diagnosis Codes ICD-CM
   Not Used

68. **Reserved for National Assignment by the NUBC**
   Not Used
69. **Admitting Diagnosis**: Required

70a-c. **Patient’s Reason for Visit**: Not Used

71. **Prospective Payment System Code**: Not Used

72. **ICD-9 External Cause of Injury Code (E-Code)**: Situational

   ICD-10 External Causes of Morbidity (V, W, X, or Y Codes): Situational

   Use when primary diagnosis is traumatic diagnosis

73. **Reserved for National Assignment by the NUBC**: Not Used

74. **Principal Procedure Code and Date**: Not Used

74a-e. **Other Procedure Codes and Dates**: Not Used

75. **Reserved for National Assignment by the NUBC**: Not Used

76. **Attending Provider Name and Identifiers**: Required

   Enter the attending practitioner’s last and first name.

   Effective 01/01/2012, enter the **National Provider Identifier (NPI)** of the attending practitioner.

77. **Operating Physician Name and Identifiers**: Not Used

78-79. **Other Provider Name and Identifiers**: Not Used

80. **Remarks**: Situational

   Use to explain unusual services and to document medical necessity and to report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

81. **Code-Code Field**

81cc.a **Taxonomy Code of the Billing Provider**: Required

   Effective 01/01/2012, enter the 10-digit Taxonomy Code of the Billing Provider, as reported to Nebraska Medicaid.

81cc.b **ZIP CODE of the Billing Provider**: Required

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