

471-000-54 Nebraska Medicaid Billing Instructions for Chiropractic 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 or enrolled in the Nebraska Health Connection Medicaid managed care plan Primary Care +. Medicaid regulations for chiropractic services are covered in 471 NAC 5-000.

Claims for services provided to clients enrolled in a Nebraska Medicaid managed care health maintenance organization plan (e.g., Share Advantage) must be submitted to the managed care plan according to the instructions provided by the plan.

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 monthly Nebraska Medicaid Card or Nebraska Health Connection ID Document. 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: Chiropractic services 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: Chiropractic services 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.

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 local HHS 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.

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 Processing
Health and Human Services Finance and Support
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 471-000-58 for an example of Form CMS-1500.

Claim Form Completion Instructions: The numbers listed below correspond to the numbers of 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). When billing for services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (see 471 NAC 1-002.02K).

- *2. **PATIENT'S NAME:** Enter the full name (last name, first name, middle initial) of the person that received services. For services provided to an ineligible mother of an eligible unborn child, enter the mother's name.

3. PATIENT'S BIRTHDATE AND SEX: Enter the month, day, and year of birth of the person that received the services. When billing for services provided to the ineligible mother of an eligible unborn child, enter the mother's date of birth (see 471 NAC 1-002.02K). Check the appropriate box (M or F).
4. INSURED'S NAME: Complete only when billing for services provided to the ineligible mother of an eligible unborn child. Enter the Medicaid client's name as it appears on the Nebraska Medicaid Card or Nebraska Health Connection ID Document. This is the name of the person (the unborn child) whose number appears in Field 1a.
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. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: Enter the initial date of treatment billed to Medicaid for the reported diagnosis.
- *21. DIAGNOSIS OR NATURE OF ILLNESS OF 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, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes for the following:
 1. The diagnosis which includes the level of subluxation (i.e., 739 or 839 series). This code must be listed as the PRIMARY diagnosis.
 2. The symptom(s) that directly relate to the diagnosis (subluxation).

The COMPLETE diagnosis code is required. (A complete code may include the third, fourth, and fifth digits, as defined in ICD-9-CM.) Diagnosis code series 739 are 4-digit codes; diagnosis code series 839 are 5-digit codes.
22. MEDICAID RESUBMISSION: Leave blank. For regulations regarding resubmittals or payment adjustment requests, see 471 NAC 3-000 and 471-000-99.

- *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.
- *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 are defined by the Centers for Medicare and Medicaid Services (CMS) and published on the CMS web site at <http://www.cms.hhs.gov>. The most commonly used national place of service codes are –

- 01 Pharmacy
- 03 School
- 04 Homeless Shelter
- 05 Indian Health Service Free-Standing Facility
- 06 Indian Health Service Provider-Based Facility
- 07 Tribal 638 Free-Standing Facility
- 08 Tribal 638 Provider-Based Facility
- 09 Prison – Correctional Facility
- 11 Office
- 12 Home
- 13 Assisted Living Facility
- 14 Group Home
- 15 Mobile Unit
- 20 Urgent Care Facility
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room – Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility

- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance - Land
- 42 Ambulance – Air or Water
- 49 Independent Clinic
- 50 Federally Qualified Health Center
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility-Partial Hospitalization
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Mentally Retarded
- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Center
- 57 Non-residential Substance Abuse Treatment Facility
- 60 Mass Immunization Center
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 65 End-Stage Renal Disease Treatment Facility
- 71 Public Health Clinic
- 72 Rural Health Clinic
- 81 Independent Laboratory
- 99 Other Place of Service

*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 used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-505).

Procedure Code Modifiers: Up to four modifiers may be entered for each procedure code.

Modifier "22" must be used when billing the initial visit only. See 471 NAC 5-004.02 for definition of the initial visit.

Modifier "52" must be used when billing for a single spinal x-ray view (anteroposterior or lateral).

24E. DIAGNOSIS POINTER: In the unshaded area, enter the diagnosis code reference number as shown in Filed 21 (1-4).

*24F. \$ CHARGES: Enter your customary charge for each procedure code. Each procedure code must have a separate charge.

*24G. DAYS OR UNITS: Enter the number of times the procedure was performed or provided on the date of service. If the procedure code description includes specific time or quantity increments, each increment should be billed as one unit of service.

- *25. FEDERAL TAX I.D. NUMBER: Complete only if enrolled with Nebraska Medicaid as a group provider. Enter the Social Security number of the practitioner providing the service.
- 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 in Field 24F. If more than one claim form is used to bill for services provided, EACH claim form must be submitted with the line items totaled. DO NOT carry charge 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 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 copayment amounts, Medicare payments, or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount) in this field.
- *30. BALANCE DUE: Enter the balance due. (This amount is determined by subtracting the amount paid in Field 29 from the total charge in Field 28.)
- *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.
- 32a. NPI #: Not used.
- 32b. Other ID #: Not used.
- *33. BILLING PROVIDER INFO & PHONE #: Enter the provider's name, address, zip code, and phone number.
- 33a. NPI #: Optional. Enter the NPI number of the billing provider.
- 33b. Other ID #: Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (example: 123456789-12). All payments are made to the name and address listed on the Medicaid provider agreement for this provider number.