

471-000-64 Nebraska Medicaid Billing Instructions for Mental Health and Substance Abuse 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 Mental Health/Substance Abuse Managed Care Program.

Medicaid regulations for mental health and substance abuse services are covered in 471 NAC 20-000 and 471 NAC 32-000. For a listing of billing instructions for all Medicaid 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 explanation of benefits, 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 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:

- Community-based (non-hospital) and supervising practitioner mental health and substance abuse 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.
- Hospital-based mental health and substance abuse services are billed to Nebraska Medicaid using standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

Paper Claims:

- Community-based (non-hospital) and supervising practitioner mental health and substance abuse services are billed to Nebraska Medicaid on Form CMS-1500, "Health Insurance Claim Form." Instructions for completing Form CMS-1500 are in this appendix.
- Hospital-based mental health and substance abuse 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 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 Web site 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 service. Check the appropriate box (M or F). When billing for services provided to the ineligible mother of an eligible unborn child, enter the mother's date of birth.
- 4. INSURED'S NAME: Complete only when billing for services provided to the ineligible mother of an eligible unborn child (see 471 NAC 1-002.02K). 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. – 11. Fields 9-11 address third party resources other than Medicare and Medicaid. If there is no known coverage, leave blank. If the client has insurance coverage other than Medicaid or Medicare, complete fields 9-11. 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.
- *14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY: When billing for residential treatment center, enhanced treatment group home, treatment group home, and treatment foster care services, enter the admission date.
- 17. NAME OF PROVIDER OR OTHER SOURCE: For consultations, enter the name of the referring/prescribing physician/practitioner.
- 17a. OTHER ID#: Leave qualifier field blank. Enter the license number of the referring physician in the shaded area of the large box in 17a.

- 17b. NPI#: Optional. Enter the NPI number of the referring provider, ordering provider or other source.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: Complete only when billing for services provided to a client during an hospital inpatient stay. Enter the date of hospital admission and, if known, the date of hospital discharge.
19. RESERVED FOR LOCAL USE: May be used to provide additional information.
20. OUTSIDE LAB: Leave blank.

CHARGES: Leave blank.

- *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, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes. Do not use codes from the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association.

The COMPLETE diagnosis code is required. A complete code may include the third, fourth and fifth digits as defined in the ICD-9-CM. Up to four diagnoses may be entered. List the primary diagnosis first.

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: For services that require prior authorization, the nine-digit prior authorization number MUST be entered in Field 23. Note: Only one prior authorization number can be entered on each claim.

- *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 Field 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.

The following services may be billed on a single claim line when the service dates are consecutive and the procedure is the same each day: Inpatient physician services, residential treatment, enhanced treatment group home, treatment group home and treatment foster care. When billing for consecutive dates, enter the begin date (From) and end date (To).

Day treatment and partial hospitalization can not be billed consecutively and must be billed on separate lines. When billing non-consecutive days, only the begin date (From) must be entered and each service must be listed on a separate line.

- *24B. PLACE OF SERVICE: In the unshaded area, enter the national two-digit place of service code that describes the location of the service that 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 common 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 Clinic
- 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 CPT or HCPCS Level II procedure code and, if required, procedure code modifier. Up to four modifiers may be entered for each procedure code. Procedure codes and modifiers used by the Nebraska Medicaid Mental Health Substance Abuse Program are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532). See page 13 of this appendix for a partial listing of procedure codes and billing instructions for mental health/substance abuse services.
- *24E. DIAGNOSIS POINTER: List the reference number of the primary diagnosis that is being treated from Field 21 (1-4). One diagnosis code may be entered per line. Do not enter codes from the DSM-IV-R.
- *24F. \$ CHARGES: Enter your customary charge for each procedure code. Each procedure code must have a separate charge. Payment for services will be made on the basis of the Nebraska Medical Assistance Program's payment methodology.
- *24G. DAYS OR UNITS: Enter the number of services being claimed. Some procedure codes are time specific. If the procedure code description includes specific time or quantity increments, each increment should be billed as one unit of service. For example, CPT procedure code 90806 is defined as 45-50 minutes of individual therapy. When billing this service, the correct unit of service is '1'.
- 24J. RENDERING PROVIDER ID#: Leave blank.
- *25. FEDERAL TAX I.D. NUMBER: Enter the Social Security number of the practitioner providing the service identified on this claim (Service Rendering Provider Number). Only one service rendering provider number may be reported per claim.
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 24, Column F. 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 applicable 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. 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: Enter the name and address of the facility where services were rendered if other than home or office. Example: school, nursing home, group home.
- 32a. NPI#: Not used.
- 32b. OTHER ID #: Not used.
- *33. BILLING PROVIDER INFO & PH# (): 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.

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 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 471-000-51 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, recommended or not used. For a summary of form locator requirements for all services, see 471-000-78.

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

FL	DATA ELEMENT DESCRIPTION	REQUIREMENT
1.	Provider Name, Address & Telephone Number	Required
2.	Pay-to Name and Address	Situational
3a.	Patient Control Number	Required
	The patient control number will be reported on the Medicaid Remittance Advice.	
3b.	Medical/Health Record Number	Situational
	The number assigned to the patient's medical/health record by the provider.	
4.	Type of Bill	Required
5.	Federal Tax Number	Required
6.	Statement Covers Period	Required
7.	Reserved for Assignment by the NUBC	Not Used

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| 8. | Patient Name/Identifier | Required |
| | <p>The patient is the person that received services. When billing for services provided to the ineligible mother of an unborn child, enter the name of the mother (see 471 NAC 1-002.02K).</p> | |
| 9. | Patient Address | Required |
| 10. | Patient Birthdate | Required |
| | <p>The patient is the person who received the services.</p> | |
| 11. | Patient Sex | Required |
| 12. | Admission/Start of Care Date | |
| | <p>Required on all inpatient claims. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy.</p> | |
| 13. | Admission Hour | Situational |
| | <p>Required on all inpatient claims. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy.</p> | |
| 14. | Priority (Type of Visit) | Situational |
| | <p>A code indicating the priority of this type of visit. Required on all inpatient claims.</p> | |
| 15. | Source of Referral for Admission or Visit | Required |
| | <p>The patient is the person that received services.</p> | |
| 16. | Discharge Hour | Situational |
| | <p>Required on all inpatient claims.</p> | |
| 17. | Patient Discharge Status | Situational |
| | <p>Required on all inpatient claims. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy.</p> | |
| 18-28. | Condition Codes | Situational |
| | <p>Use if applicable</p> | |
| 29. | Accident State | Not Used |

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

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

Required for traumatic diagnoses. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy. Use other occurrence codes if applicable.

35-36. Occurrence Span Codes and Dates **Situational**

A code and related dates that identify an event that relates to payment of the claim. These codes identify occurrences that happened over a span of time.

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

38. Responsible Party Name and Address **Situational**

Use if applicable.

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

Use value code 80 to report covered days, 81 to report non-covered days, 82 to report co-insurance days, and 83 to report lifetime reserve days.

42. Revenue Code **Required**

43. Revenue Description **Required**

44. HCPCS/Rates/HIPPS Rate Codes **Situational**

HCPCS procedure codes are required on all mental health/substance abuse claims, except pharmacy and supplies. See page 13 of this appendix for a partial listing of procedure codes and billing instructions for mental health/substance abuse services. Procedure codes and modifiers used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532). Up to four procedure code modifiers may be entered for each procedure code.

Rates are required on acute psychiatric inpatient claims for accommodation rooms.

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| 45. Service Date | Situational |
| Required on outpatient claims with date spans (FL6) greater than one calendar day, except dialysis, cardiac rehab, and ambulatory room and board services. | |
| 46. Units of Service | Required |
| Units must be whole numbers. No decimals or fractions are permitted. | |
| 47. Total Charges (by Revenue Code Category) | Required |
| Total charges must be greater than zero. Do not submit negative amounts. | |
| 48. Non-Covered Charges | Situational |
| Enter only Nebraska Medicaid non-covered charges. Do not submit negative amounts. | |
| 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 explanation of 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). | |
| 55. Estimated Amount Due | Not Used |
| 56. National Provider Identifier – Billing Provider | Situational |
| The unique identification number assigned to the provider submitting the claim. | |
| 57. Other Provider Identifier | Required |
| 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. | |

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| 58. Insured's Name | Required |
| When billing for services provided to the ineligible mother of an eligible unborn child, enter the name of the unborn child as it appears on the Nebraska Medicaid Card or Nebraska Health Connection ID Document. | |
| 59. Patient's Relationship to Insured | Required |
| Use patient relationship code 18 for all claims. | |
| 60. Insured's Unique Identification | Required |
| 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. | |
| 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 | Situational |
| Required on all inpatient claims. Required on outpatient claims for partial hospitalization. Required for outpatient therapy services for clients participating in the Nebraska Medicaid mental health/substance abuse managed care plan. | |
| 64. Document Control Number (DCN) | Situational |
| 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) | Not Used |
| 67. Principal Diagnosis Code | Required |
| The COMPLETE ICD-9-CM diagnosis code is required. A complete code may include the third, fourth, and fifth digits, as defined in ICD-9-CM. Do not use DSM-IV codes. | |

67A-Q. Other Diagnosis Codes--ICD-9-CM

Situational

Required if more than one diagnosis applies to the services on this claim.

68. Reserved for National Assignment by the NUBC

Not Used

69. Admitting Diagnosis

Situational

Required on all inpatient claims. Required on outpatient claims for emergency room services.

70a-c. Patient's Reason for Visit

Situational

71. Prospective Payment System (PPS) Code

Not Used

72. External Cause of Injury Code (E-Code)

Situational

Required if the principal diagnosis is trauma.

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

The practitioner license number must begin with the two-digit state abbreviation followed by the state license number (example: NE123456).

Enter the attending practitioner's last and first name.

77. Operating Physician Name and Identifiers

Not Used

78-79. Other Provider Names and Identifiers

Not Used

80. Remarks

Situational

Use to explain unusual services and to document medical necessity, for example, when unit limitations are exceeded. Required for outpatient stays greater than 24 hours.

81. Code-Code Field

Situational

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.

Procedure Codes and Billing Instructions for Mental Health/Substance Abuse Services:

Community Treatment Aide I: Use procedure code G0177 and modifier HN (Training and educational services related to the care and treatment of patient's disabling mental health problems, per session 45 minutes or more). One unit is 60 minutes. Report the number of units per visit. Bill on Form CMS-1500. Note: Covered for both Fee-For-Service and managed care clients.

Community Treatment Aide II: Use procedure code G0177 and modifier HM (Training and educational services related to the care and treatment of patient's disabling mental health problems, per session 45 minutes or more). One unit is 60 minutes. Report the number of units per visit. Bill on Form CMS-1500. Note: Covered for Fee-For-Service clients only.

Continuing Community Treatment Aide: Use procedure code G0177 and modifier 52 (Training and educational services related to the care and treatment of patient's disabling mental health problems, per session 45 minutes or more). One unit is 60 minutes. Report the number of units per visit. Bill on Form CMS-1500. Note: Covered for managed care clients only.

Day Treatment, Full Day: Use procedure code H2012 (Behavioral health day treatment, per hour). Each full day service must be billed on a separate claim line. The unit of service for each line must be reported as 6. Bill day treatment on Form CMS-1500. Note: Covered for Fee-For-Service clients only.

Day Treatment, Half-Day: Use procedure code H2012 and modifier 52 (Behavioral health day treatment, per hour). Each half-day service must be billed on a separate claim line. The unit of service for each line must be reported as 3. Bill day treatment on Form CMS-1500. Note: Covered for both Fee-For-Service and managed care clients.

Day Treatment, Extended Day: Use procedure code H2012 and modifier TU (Behavioral health day treatment, per hour). One unit is one hour. Bill on Form CMS-1500. Note: Covered for Fee-For-Service clients only.

Partial Hospitalization, Full-Day: Use procedure code H2012 (Behavioral health day treatment, per hour). Each full day service must be billed on a separate claim line. The unit of service for each line must be reported as 6. Bill partial hospitalization on Form CMS-1450. Note: Covered for managed care clients only.

Partial Hospitalization, Half-Day: Use procedure code H2012 and modifier 52 (Behavioral health day treatment, per hour). Each half-day service must be billed on a separate claim line. The unit of service for each line must be reported as 3. Bill partial hospitalization on Form CMS-1450. Note: Covered for managed care clients only.

Family Assessment: Use procedure code H1011 (Family assessment by licensed behavioral health professional for state defined purposes). Report one unit per assessment. Bill community-based (non-hospital) services on Form CMS-1500 and outpatient hospital-based services on Form CMS-1450.

Intensive Outpatient Service (Bundled): Use procedure code S9480 (Intensive outpatient psychiatric services, per diem). This service is bundled for managed care clients only. One day is one unit. For fee-for-service clients, bill each service separately (i.e., individual, family or group therapy). Each service is one unit. Bill community-based (non-hospital) services on Form CMS-1500 and outpatient hospital-based services on Form CMS-1450.

Mileage: Use procedure code 99082. The unit of service is the total number of miles traveled. Bill on Form CMS-1500.

Pre-Treatment Assessment: Use procedure code H0002 (Behavioral health screening to determine eligibility for admission to treatment program). Each complete assessment is one unit. Bill community-based (non-hospital) services on Form CMS-1500 and outpatient hospital-based services on Form CMS-1450.

Pre-Treatment Assessment Addendum: Use procedure code H0002 and modifier 52 (Behavioral health screening to determine eligibility for admission to treatment program). Each addendum is one unit. Bill community-based (non-hospital) services on Form CMS-1500 and outpatient hospital-based services on Form CMS-1450.

Psychological Testing: Use procedure code 96101 for testing. Total number of units equals number of hours of testing for that date of service. Use procedure code 96101 and modifier 52 for a half hour of testing. One unit is one half-hour. Bill community-based (non-hospital) services on Form CMS-1500 and outpatient hospital-based services on Form CMS-1450.

Supervising Practitioner (M.D. or Ph.D.) Services: Use the appropriate procedure code for the service. Bill on Form CMS-1500.

Day Residential Crisis Intervention (up to 23 hours and 59 minutes): Use procedure code S9484 (Crisis intervention mental health services, per hour). Report the number of hours as the units of service. Bill on Form CMS-1450.

Residential Acute Crisis Intervention: Use procedure code S9485 (Crisis intervention mental health services, per diem). One unit is one day. Bill community-based (non-hospital) services on Form CMS-1500 and hospital-based services on Form CMS-1450.

Residential Treatment Center:

- For hospital-based services, use procedure code H0017 and modifier TG (Behavioral health; residential [hospital residential treatment program], without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. Bill on Form CMS-1450. Supervising practitioners bill on Form CMS-1500. One unit is one day.

- For community-based (non-hospital) services, use procedure code H0018 and modifier TG (Behavioral health; short-term residential [non-hospital residential treatment program], without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. One unit is one day. Bill on Form CMS-1500.

Therapeutic Leave Days: One unit is one day. When billing therapeutic leave days on Form CMS-1500, report the procedure code for the service the client is receiving and place of service code 12. When billing therapeutic leave days on Form CMS-1450, report the procedure code for the service the client is receiving and revenue code 183.

Treatment Foster Care: One unit is one day. Use procedure code S5145 (Foster care, therapeutic, child; per diem). Bill on Form CMS-1500.

Treatment Group Home:

- For hospital-based services, use procedure code H0017 (Behavioral health; residential [hospital residential treatment program], without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. One unit is one day. Bill on Form CMS-1450. Supervising practitioners bill on Form CMS-1500.
- For community-based (non-hospital) services, use procedure code H0018 (Behavioral health; short-term residential [non-hospital residential treatment program], without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. One unit is one day. Bill on Form CMS-1500.

Enhanced Treatment Group Home (Managed Care Service Only):

- For hospital-based services, use procedure code H0017 and modifier TF (Behavioral health; residential [hospital residential treatment program], without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. One unit is one day. Bill on Form CMS-1450. Supervising practitioners bill on Form CMS-1500.
- For community-based (non-hospital) services, use procedure code H0018 and modifier TF (Behavioral health; short-term residential [non-hospital residential treatment program], without room and board, per diem). When the service includes room and board, use modifier U1 (Service includes room and board) as the second modifier. For newly enrolled facilities that are not nationally accredited, modifier U1 should not be used since the Medicaid payment rate does not include room and board. One unit is one day. Bill on Form CMS-1500.

Telehealth Services: Medicaid policy regarding telehealth services is covered in 471 NAC 1-006. To bill for a telehealth service, use the standard CPT/HCPCS procedure code for the service (e.g., office visit, consultation) with procedure code modifier GT. To bill for telehealth transmission costs, use procedure code T1014 and enter the number of minutes of transmission as the units of service. When billing for outpatient services or for supervising practitioner services at the higher levels of care, each day the service is provided via telehealth must be listed on a separate line. For these days, there should also be a separate line billed for the telehealth transmission cost. There is no additional reimbursement for the telehealth transmission charges for these levels of care, but Nebraska Medicaid must track and analyze the use of telehealth services. Bill community-based (non-hospital) services on Form CMS-1500 and hospital-based services on Form CMS-1450. Supervising practitioners bill on Form CMS-1500.

Injectable Mental Health Substance Abuse Drugs: For injectable mental health substance abuse drugs given in a community-based setting, enter the Nebraska Medicaid HCPCS or CPT code in the unshaded area of 24D. Enter the National Drug Code (NDC), the name of the drug and the dosage in the shaded area of 24D through 24H. For injectable mental health substance abuse drugs given in an outpatient hospital setting, enter the appropriate revenue code in field 42 and the HCPCS code in field 44. An invoice must be attached to the claim which notes the patient's name, date of injection, dose and provider's cost.

CCA Evaluations for Youth in Detention: For youth temporarily in detention pending other arrangements, use procedure code H2000 and Place of Service Code 09. Enter the name and address of the detention facility in Field 32. Bill on Form CMS-1500.