

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 or enrolled in the Nebraska Health Connection Medicaid managed care plan Primary Care +, and Share Advantage. 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 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: 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 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.

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 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

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
4.	Type of Bill	Required
	Valid hospice bill types = 81X & 82X	
5.	Federal Tax Number	Required
6.	Statement Covers Period	Required
7.	Reserved for National Assignment by the NUBC	Not Used
8.	Patient Name/Identifier	Required
9.	Patient Address	Required
10.	Patient Birthdate	Required
11.	Patient Sex	Required
12.	Admission/Start of Care Date	Required
13.	Admission Hour	Not Used
14.	Priority (Type of Visit)	Not Used
15.	Source of Referral for Admission or Visit	Not Used
16.	Discharge Hour	Not Used
17.	Patient Discharge Status	Required
	<u>Must be sent on every Hospice claim and should reflect the status of the patient on the last day of the claim.</u>	

18-28.	Condition Codes Use if applicable.	Situational
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.	Situational
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: <ul style="list-style-type: none">• 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.	Situational
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	Situational
42.	Revenue Code 651 - Routine Home Care 652 - Continuous Home Care 655 - Inpatient Respite Care 656 - General Inpatient Care No other revenue codes accepted.	Required
43.	Revenue Description	Not Used

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| 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. | Required |
| 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 | Situational |
| 46. | Units of Service
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) | Required |
| 47. | Total Charges (by Revenue Code Category)
Total charges must be greater than zero.
Do not submit negative amounts.
Each procedure code/line/date must have a separate charge. | Required |
| 48. | Non-Covered Charges
Do not bill charges that are not covered by Nebraska Medicaid Hospice Program | Not Used |
| 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
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). | Situational |
| 55. | Estimated Amount Due | Not Used |

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| 56. | National Provider Identifier – Billing Provider
The unique identification number assigned to the provider submitting the claim. | Situational |
| 57. | Other Provider Identifier
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. | Required |
| 58. | Insured’s Name
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. | Required |
| 59. | Patient’s Relationship to Insured | Required |
| 60. | Insured’s Unique Identification
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. | Required |
| 61. | (Insured) Group Name
Recommended when Nebraska Medicaid is the secondary payer | Situational |
| 62. | Insurance Group Number
Recommended when Nebraska Medicaid is the secondary payer. | Situational |
| 63. | Treatment Authorization Code | Required |
| 64. | Document Control Number (DCN)
Required when Type of Bill Frequency Code (FL04) indicates this claim is a replacement claim or void to a previously adjudicated claim. | Required |
| 65. | Employer Name of the Insured | Not Used |
| 66. | Diagnosis and Procedure Code Qualifier
(ICD Version Indicator) | Not Used |
| 67. | Principal Diagnosis Code
Must match the primary diagnosis code on prior authorization form | Required |
| 67A-Q. | Other Diagnosis Codes—ICD-9-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.	External Cause of Injury Code (E-Code) Use when primary diagnosis is traumatic diagnosis	Situational
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 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.	Required
77.	Operating Physician Name and Identifiers	Not Used
78-79.	Other Provider Name and Identifiers	Not Used
80.	Remarks Use to explain unusual services and to document medical necessity.	Situational
81.	Code-Code Field 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.	