

# PROVIDER BULLETIN

No. 08-05

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TO: Hospitals participating in the Nebraska Medicaid Program.

FROM: Vivianne M. Chaumont, Director   
Division of Medicaid & Long-Term Care  
Department of Health and Human Services

**RE: HOSPITAL BILLING INSTRUCTIONS FOR CLAIMS WITH SHARE OF COST**

Please share this information with administrative, clinical and billing staff.

Share of cost, also known as spend-down, is a provision that allows a person whose income is more than the standard to receive some assistance with medical bills under Medicaid. The amount of a person's share of cost is the amount of medical expenses that Medicaid won't pay for *each month*.

## FREQUENTLY ASKED QUESTIONS

1. How do I know when a client has a share of cost?

The provider can determine if the client has a share of cost in one of four ways. One is by calling the Nebraska Medicaid Eligibility System (NMES) Line at 1-800-642-6092 or, if calling from Lincoln, at 402-471-9580. A second way is to call the Medicaid Inquiry Line at 877-255-3092. In addition to notifying the provider that the client has a share of cost, the Inquiry Line can also report the amount of the share of cost. The amount of the share of cost is not available through the NMES Line. A third way is when a client presents a share of cost form. And finally the provider can contact the Local Office.

2. The Share of Cost form was sent to Medicaid but the client is still ineligible. Why is the client still not eligible?

The share of cost form should be submitted when all sections are completed by both the client and the provider and the client has fully met their obligation. In some cases the client obligates a portion of their share of cost to more than one provider. Until the client has fully obligated the entire share of cost amount the client remains ineligible. The client cannot obligate more than the billed charges from the provider. If there is not space on the form to add additional share of cost amounts, the provider can request a second form from the local office. The share of cost form should be submitted to Medicaid either before a claim is sent in or it can be sent in with the claim.

3. What if two providers have incurred a share of cost?

Only enter the amount incurred by the individual provider. For instance if the client obligated \$50 to the physician and \$50 to the hospital, each provider enters only \$50 on the share of cost form and on the claim.

4. When an inpatient claim spans two months and the client has met his/her share of cost amount for the first month but not the second month how do I bill the claim?

In this situation, the claim should be submitted as an interim bill type 112. Enter the admission date in form locator 12. The admission date should be the same as the "from date" in form locator 6. Do not enter a discharge hour. Client discharge status should be 30 "still a patient". Enter the share of cost amount in form locator 54c. Only include diagnosis codes, revenue codes, and charges for the first month (the month that the share of cost was met).

5. When an inpatient claim spans two months and the client has met his/her spend down amount for the second month but not the first month how do I bill the claim?

In this situation the claim should be submitted as a final bill type 114. Admission date in form locator 12 should be the actual date the client was admitted. In form locator 6 enter only the dates of service that the client was eligible during the second month. In form locator 16 a discharge hour must be included. Include only diagnosis codes, revenue codes, and charges for the second month (the month that the share of cost was met).

6. If a client in managed care (Share Advantage) is hospitalized as an inpatient and incurs a share of cost for the second month of the hospitalization, who is responsible for payment of the claim?

Share Advantage would be responsible for payment of the first month. The claim should be sent to Share Advantage as an interim bill type. See instructions under #4 for submitting an interim claim. If the client meets the Share of Cost for the second month the claim is sent to Medicaid as a final bill type with a copy of the EOB from Share Advantage. If the claim is reimbursed a DRG payment by both Share Advantage and Medicaid Fee-For-Service, the provider will receive a single DRG payment with an outlier amount if applicable. The provider is not entitled to two payments for the one stay. The payment from Share Advantage will be subtracted from the Medicaid allowable for the final bill. If the claim is reimbursed a per diem by Share Advantage and a DRG by Medicaid, the first month of the claim will be reimbursed a per diem and the second month a DRG payment.

7. How do I submit a claim when the client has Share of Cost with both Medicare and Medicaid coverage and the claim spans two months.

Medicare must be billed first and the provider must obtain an Explanation of Benefits (EOB). If there is a deductible due on the first day of the month and the client is not eligible the first month, Medicaid will deny the claim. In this case the provider may bill the client for the deductible. If the client is eligible the second month and a co-insurance amount is due, Medicaid will pay the co-insurance.

8. If Medicare pays a claim in full and no Coinsurance or Deductible is due can that claim be used to clear a Share of Cost?

No.

9. For an inpatient claim, if the client has Medicare Part B only do you need an EOB to clear the Share of Cost?

Yes, an EOB is necessary to process the claim. The claim will not crossover unless the Share of Cost has been met.

If you have any questions regarding the information in this bulletin please contact Margaret Booth at 402-471-9380 or [margaret.booth@dhhs.ne.gov](mailto:margaret.booth@dhhs.ne.gov)