

PROVIDER BULLETIN

No. 14-09

Date: February 14, 2014

TO: Nursing Facility, and Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Providers

FROM: Vivianne M. Chaumont, Director 
Division of Medicaid & Long-Term Care

BY: Sue Clark, Program Specialist
Division of Medicaid & Long-Term Care

RE: Billing for Durable Medical Equipment in Nursing Facilities and Intermediate Care Facilities

Please Share This Information with Administrative, Clinical and Billing Personnel

Beginning August 1, 2013, Medicaid implemented changes for coverage of durable medical equipment (DME) provided to a patient in a nursing facility (NF) or intermediate care facility (ICF). Please See Provider Bulletin # 13-34.

Most DME is covered in the NF and ICF per diem and separate payment is not available. However, there are some items that are not considered to be part of the facility's Medicaid per diem for which payment may be made to NF and ICF providers. Those items are listed below. To be covered, the client's condition must meet the coverage criteria for the item outlined in the appropriate Medicaid provider chapter.

1. Non-standard wheelchairs, including power-operated vehicles, and wheelchair seating systems, including certain pressure reducing wheelchair cushions, needed for the client's permanent and full time use (see 471 NAC 7-000);
2. Air fluidized bed units and low air loss bed units (see 471 NAC 7-000); and
3. Negative Pressure Wound Therapy, See 471 NAC 7-000).

Separate reimbursement to Nursing Facility and ICF/DD providers for these items is based on the Medicaid fee schedule.

Billing instructions for NFs and ICFs submitting a claim for durable medical equipment provided to a client in a NF and ICF can be found at: <http://dhhs.ne.gov/Documents/471-000-80.pdf>

Providers are reminded of the necessity to utilize appropriate **HCPCS Codes and Modifiers** in Field #44 of the CMS-1450 (UB-04) claim form. Examples of required modifiers for these specific DME items may include, but are not limited to: NU; RB; RR; KR; GY. Consult your HCPCS Code Book for definitions and appropriate use. However, note that per the HCPCS Code Book, modifier GY is intended to be used when an item or service does not meet the definition of a Medicare covered benefit.

Since nursing facilities cannot bill **Medicare** for the DME items specified above, the DME provider will need to submit the claim on their behalf. Once processed, the DME provider will need to provide the nursing facility or intermediate care facility with the explanation of benefits from Medicare (EOMB) so it they can include it with their claim form when filing with Nebraska Medicaid.

If nursing facilities are sending claims for dual eligible clients on to Medicaid directly, they need to be sure to include a copy of the Medicare EOMB and the payment from other sources (POS) information in Field #54 (required for dual eligibles) in order for the claim to process correctly.

If you have claims questions regarding this bulletin, please contact the Medicaid Inquiry Line at 877-255-3092 or 402-471-9128.

If you have specific program/policy questions regarding this bulletin, please contact Sue Clark at sue.clark@nebraska.gov.