471-000-53 Nebraska Medicaid Billing Instructions for Ambulance 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. Medicaid regulations for ambulance services are covered in 471 NAC 4-000.

CMS 1500 Claim Form Versions

In November, 2013, Nebraska Medicaid published implementation information regarding the revised CMS 1500 claim form (version 02/12). The transition timeline for dual processing and acceptance of ONLY the CMS 1500 claim form (version 02/12) may be found in that Provider Bulletin 13-75 at this site:
http://dhhs.ne.gov/medicaid/Documents/pb1375.pdf

Please note that on or after **April 1, 2014**, any claims received utilizing the older versions of the CMS 1500 claim form will be returned to the provider.

NOTE: For ambulance services provided by a hospital, see regulations outlined in 471 NAC 10-000 and billing instructions in 471-000-52.

Claims for services provided to clients enrolled in a Nebraska Medicaid managed care health maintenance organization plan 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, explanation of benefits, 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 permanent Nebraska Medicaid Identification Card or temporary Nebraska Medicaid Presumptive Eligibility Application. 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: Ambulance 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: Ambulance 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 DHHS 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-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 Unit
Division of Medicaid and Long-Term Care
Department of Health and Human Services
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).

*2. PATIENT'S NAME: Enter the full name (last name, first name, middle initial) of the person that received services.

3. PATIENT'S BIRTHDATE AND SEX: Enter the month, day, and year of birth of the person that received the services. Check the appropriate box (M or F).

9. – 14. Fields 9-11 and 14 address third party resources other than Medicare and Medicaid. 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.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: Complete only when billing for services provided to a client during a hospital inpatient stay. Enter the date of hospital admission and, if known, the dates of hospital discharge. Note: For clients whose participation in Medicaid managed care begins, ends or whose Medicaid managed care plan changes during a hospital inpatient stay, claims for services provided DURING the hospital inpatient stay must be submitted to the plan in which the client was enrolled at the time of the hospital admission.

19. Version (02/12) ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Version (08/05) RESERVED FOR LOCAL USE: May be used to provide additional information.

*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, Clinical Modification diagnosis codes that substantiate the need for ambulance transportation.

The COMPLETE diagnosis code is required.

CMS 1500 claim form (version 08-05) will be accepted through March 31, 2014. For claims being submitted on this version there are up to four diagnoses that may be entered in 1-4. If there is more than one diagnosis, list the primary diagnosis first.

CMS 1500 claim form (version 02-12) is currently accepted. For dates of service on or before September 30, 2015 only ICD-9 codes will be accepted on this form. For dates of service on or after October 1, 2015 only ICD-10 codes will be accepted.

For claims being submitted on the CMS 1500 claim form (version 02-12) there are up to twelve diagnoses that may be entered in A-L. If there is more than one diagnosis, list the primary diagnosis first.

ICD VERSION INDICATOR: On the CMS 1500 (version 02/12) the **ICD Version Indicator is required**. The ICD qualifier located in this section denotes the version of International Classification of Diseases reported.

The ICD Version Indicator will be used to distinguish if the submitted Code is an ICD-9 or an ICD-10 Code.

Version ‘9’ indicates the Codes entered as ICD-9 Diagnosis Code.

Version '0' indicates the Codes entered as ICD-10 Diagnosis Code.

If the diagnosis code does not clearly substantiate the medical need for non-emergency transports, the provider should attach additional documentation to the claim (e.g., a copy of the Medicare medical necessity for ambulance transport form, the "patient encounter form," or other documentation). When billing for more than one transport, the medical necessity for each transport must be substantiated. Nebraska Medicaid may request additional documentation prior to payment of a claim if medical necessity is not substantiated.

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 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 "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 common national place of service codes for ambulance services are listed below.

41 Ambulance - Land
42 Ambulance - Air or Water

*24D. PROCEDURES, SERVICES, OR SUPPLIES: In the unshaded area, enter the appropriate national HCPCS procedure code and, if required, procedure code modifier.

Procedure Codes: HCPCS procedure codes used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-504). When using miscellaneous and not otherwise classified (NOC) procedure codes, a complete description of the service is required in the shaded area between 24D through 24H or as an 8 ½ x 11 attachment to the claim.

Procedure Code Modifiers: The following procedure code modifiers are required with all transport procedure codes. The first-place alpha code represents the origin, and the second-place alpha code represents the client's destination. Codes may be used in any combination unless otherwise noted.

D - Diagnostic or therapeutic site (other than physician's office or hospital)
E - Residential, domiciliary or custodial facility (other than skilled nursing facility)
G - Hospital-based dialysis facility (hospital or hospital-related)
H - Hospital
I - Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J - Non-hospital-based dialysis facility
N - Skilled nursing facility
P - Physician's office (includes HMO non-hospital facility, clinic, etc.)
R - Residence
S - Scene of accident or acute event
X - (DESTINATION CODE ONLY) Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

24E. DIAGNOSIS POINTER:

Version (02/12) On the CMS 1500 claim form list the reference letter of the primary diagnosis that is being treated from Field 21 (A-L). Up to four diagnosis pointers may be entered per line.
Version (08/05) On the CMS 1500 claim form list the reference number of the primary diagnosis that is being treated from Field 21 (1-4). On the CMS 1500 claim form (version 02-12) list the reference letter of the primary diagnosis that is being treated from Field 21 (A-L). One diagnosis pointer may be entered per line.

*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 service was 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.

For ambulance mileage, enter the number of allowable "loaded" miles.
For standby/waiting time, use the following table to determine units of service:

Units	Time	Units	Time
1	1/2 to 1 hr.	6	3 to 3 1/2 hrs.
2	1 to 1 1/2 hrs.	7	3 1/2 to 4 hrs.
3	1 1/2 to 2 hrs.	8	4 to 4 1/2 hrs.
4	2 to 2 1/2 hrs.	9	4 1/2 to 5 hrs.
5	2 1/2 to 3 hrs.	10	5 to 5 1/2 hrs.

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, Medicare payments, or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount) in this field.

*30. Version (02/12) RSVD FOR NUCC USE

Version (08/05) BALANCE DUE: Provider may 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.

*33. BILLING PROVIDER INFO & PHONE#: Enter the provider's name, address, nine-digit zip code, and phone number.

Effective 01/01/2012, enter the **nine-digit Zip Code (Zip+4)** of the Billing Provider, as reported to Nebraska Medicaid.

*33a. NPI#: Effective 01/01/2012, enter the **National Provider Identifier (NPI)** of the Billing Provider, as reported to Nebraska Medicaid.

*33b. OTHER ID#: Effective 01/01/2012, enter the 10-digit **Taxonomy Code** of the Billing Provider, as reported to Nebraska Medicaid.