471-000-65 Nebraska Medicaid Billing Instructions for Visual Care Services

The billing 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 visual care services are covered in 471 NAC 24-000.

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.

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: Visual care 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.
Please continue billing instructions on this page

Paper Claims: Visual care 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.

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 website 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 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.

17. NAME OF PROVIDER OR OTHER SOURCE: Enter the name of the prescribing physician/practitioner when billing for lenses, frames and other vision appliances.

19. Version (02/12) ADDITIONAL CLAIM INFORMATION (Designated by NUCC): When using procedure code V2799 and other miscellaneous and not otherwise classified (NOC) procedure codes, a complete description of the service is required in Field 19 or as an 8 ½ x 11" attachment to the claim. Include the line number and description of the item/service provided.

Version (08/05) RESERVED FOR LOCAL USE

*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, Clinical Modification diagnosis codes.

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. On or before September 30, 2015 only ICD-9 codes will be accepted on this form. 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: 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.

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 Filed 24. Do not print more than one line of information on each claim line. DO NOT LIST services for which there is no charge. **In the shaded area, when billing for lenses and frames, enter the appropriate condition code for each line to document the reason for replacement.**

L1 – General standard of 20 degree or .5 diopter sphere or cylinder change me
L2 – Replacement due to loss or theft
L3 – Replacement due to breakage or damage
L5 – Replacement due to medical reason

*24A. DATE(S) OF SERVICE: In the unshaded area, enter 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. For eyeglasses, the date of service may be shown as the date ordered by provider or date delivered, **however, the claim cannot be submitted to Nebraska Medicaid until the item has been delivered to the client.**

*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 commonly used 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 Center
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 procedure code and, if required, procedure code modifier. Up to four modifiers may be entered for each procedure code. HCPCS procedure codes used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-524).

When using procedure code V2799 and other miscellaneous and not otherwise classified (NOC) procedure codes, a complete description of the service is required in Field 19 or as an 8½ x 11" attachment to the claim. Include the line number and description of the item/service provided.

Fitting of Eyeglasses: Modifier 52 must be used with procedure codes for eyeglass fitting (92340-92353) when billing a frame only or lenses only.

Prescription and Fitting of Contact Lenses: Modifier 52 must be used with procedure codes for prescription and fitting of contact lenses when provided for only one eye.

Special Lens Materials: An Invoice must be attached when billing lens procedure codes for special lens material (e.g., thin polycarbonate, high index, etc.).

Special Lens Procedures or Features: Bill special lens procedures or features in addition to the lens code. Examples include: bifocal segment widths over 28mm, slab-off prisms, tints, oversize lenses, polycarbonate lenses, etc.

Telehealth Services: Medicaid policy regarding telehealth services is in 471 NAC 1-006. To bill for a telehealth service, use the 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 in Field 24G.

Post-Operative Care: Nebraska Medicaid payment for a surgical procedure includes 14-days post-operative care. When a surgical procedure and post-operative care is not performed by the same practitioner, bill post-operative care using the appropriate CPT procedure code for the service provided (e.g., office visit). Do not use the surgical procedure code with modifier "55."

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. **All frames and lenses must be billed at the actual cost (including discounts) from the provider's supplier.**

*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.

24J. RENDERING PROVIDER ID #: Complete only if enrolled with Nebraska Medicaid as a group provider. Only one rendering provider may be reported per claim.

Effective 01/01/2012, enter the National Provider Identifier (NPI) of the rendering provider.

25. FEDERAL TAX I.D. NUMBER: Effective 01/01/2012, the field is no longer required.

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.

32a. NPI #: Not used.

32b. Other ID #: Not used.

*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.

Claim Attachments: Nebraska Medicaid no longer requires submission of invoices with all claims for eyeglass frames and lenses. A copy of the invoice from the lens/frame supplier is required only when billing for special lens features and lab procedures. Providers should retain all supplier invoices in their records. Nebraska Medicaid retains the right to review invoices on a case-by-case basis.