471-000-77 Nebraska Medicaid Billing Instructions for Rural Health Clinic 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 rural health clinic services are covered in 471 NAC 34-000. For a listing of billing instructions for all Medicaid services, see 471-000-49.

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, 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. For clients who do not have Medicare Part A coverage or who have exhausted Medicare Part A benefits, all Medicare Part B covered services must be submitted to Medicare prior to billing Medicaid for inpatient hospital services.

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: For electronic transaction submission instructions, see 471-000-50.

- Rural health services, as defined in 471 NAC 34-003, are billed to Nebraska Medicaid under the provider's rural health provider number using the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

- Non-rural health clinic services, as defined in 471 NAC 34-003, are billed to Nebraska Medicaid under the provider's non-rural health provider number using the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

Paper Claims:

- Rural health services, as defined in 471 NAC 34-003, are billed to Nebraska Medicaid under the provider's rural health provider number on Form CMS-1450, "Health Insurance Claim Form." Instructions for completing Form CMS-1450 are in this appendix.

- Non-rural health clinic services, as defined in 471 NAC 34-003, are billed to Nebraska Medicaid under the provider's non-rural health provider number on Form CMS-1500, "Health Insurance Claim Form." Instructions for completing Form CMS-1500 are in appendix 471-000-62.

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

Instructions for completing Form CMS-1500 for non-rural health services are in appendix 471-000-62.

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 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 471-000-51 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, recommended or not used. Unlabeled form locators are not included in these instructions. For a summary of form locator requirements for all services, see 471-000-78.

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

FL	DATA ELEMENT DESCRIPTION	REQUIREMENT
1.	**Provider Name, Address & Telephone Number**	**Required**
2.	**Reserved**	**Not Used**
3a.	**Patient Control Number**	**Required**

The patient control number will be reported on the Medicaid Remittance Advice.

3b.	**Medical /Health Record Number**	**Situational**

The number assigned to the patient's medical/health record by the provider.

4.	**Type of Bill**	**Required**
5.	**Federal Tax Number**	**Required**
6.	**Statement Covers Period**	**Required**

The statement covered period may not exceed one calendar day. Each one number must be billed on a separate claim.

7.	**Reserved for Assignment by NUBC**	**Not Used**
8.	**Patient Name/Identifier**	**Required**

The patient is the person that received services.

9.	**Patient Address**	**Required**

The patient is the person that received services.

10.	**Patient Birthdate**	**Required**

The patient is the person that received services.

11.	**Patient Sex**	**Required**
12.	**Admission/Start of Care Date**	**Not Used**

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 **Not Used**

18-28. Condition Codes **Not Used**

29. Accident State **Not Used**

30. Reserved for Assignment **Not used**

31-34. Occurrence Codes and Dates **Situational**

A code and associated date defining a significant event relating to the claim that may affect payor processing. Required for traumatic diagnoses.

35-36. Occurrence Span Code and Dates **Not Used**

37. Reserved for assignment **Not Used**

38. Responsible Party Name and Address **Not Used**

39-41. Value Codes and Amounts **Situational**

42. Revenue Code **Required**

43. Revenue Description **Required**

When using miscellaneous and not otherwise classified (NOC) procedure codes, a complete description of the service is required.

44. HCPCS/Rates/HIPPS Rate Codes **Situational**

HCPCS procedure codes are required on inpatient claims for “other therapeutic services” (revenue codes 940 and 949). HCPCS procedure codes are required on all outpatient claims except pharmacy, supplies and dialysis. Up to four procedure code modifiers may be entered for each procedure code.

HIPPS rate codes are not used.

45. Service Date **Required**

46. Units of Service **Required**

Units must be whole numbers. No decimals or fractions are permitted.

47. Total Charges (by Revenue Code Category) **Required**

Total charges must be greater than zero unless two or more operative procedures during a single session are billed. Only the first procedure requires a charge. Do not submit negative amounts.

48. Non-Covered Charges **Not Used**

49. Reserved for Assignment **Not Used**

50. Payer Name **Not Used**

51. Health Plan Identification Number **Not Required**

52. Release of Information Certification Indicator **Not Used**

53. Assignment of Benefits Certification Indicator **Not Used**

54. Prior Payments - Payers **Situational**

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 explanation of 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).

55. Estimated Amount Due - Payer **Not Used**

56. National Provider Identifier – Billing Provider **Required**

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

57. Other Provider Identifier **Not Used**

All payments are made to the name and address listed on the Medicaid provider agreement for this provider number.

Effective 01/01/2012, this field is no longer required.

58. Insured's Name **Not Used**

59. Patient's Relationship to Insured **Required**

Use patient relationship code 18 for all claims.

60. Insured's Unique Identification **Required**

Enter the Medicaid client's complete eleven-digit identification number (example: 123456789-01).

61. (Insured) Group Name **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

62. Insurance Group Number **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

63. Treatment Authorization Code **Not Used**

64. Document Control Number (DCN) **Situational**

Required when Type of Bill Frequency Code (FL04) indicates this claim is a replacement claim or void to a previously adjudicated claim.

65. Employer Name of the Insured **Not Used**

66. Diagnosis and Procedure Code Qualifier (ICD Version Indicator) **Required**

The qualifier 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 or Surgical Procedure Code.

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

67. Principal Diagnosis Code **Required**

Enter the International Classification of Diseases-Clinical Modification (ICD-CM) code describing the principal/primary diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care). The COMPLETE diagnosis code is required, as defined in ICD-CM.

67 A-Q. Other Diagnosis Codes ICD-CM **Situational**

Enter the ICD-CM codes corresponding to conditions that co-exist at the time of admission, or that develop subsequently, and that affect the treatment received and/or the length of stay.

68. Reserved for Assignment by the NUBC **Not Used**

69. Admitting Diagnosis **Not Used**

70 a-c. Patient's Reason for Visit **Not Used**

71. Prospective Payment System (PPS) Code **Not Used**

72. ICD-9 External Cause of Injury (ECI) Code **Situational**

ICD-10 External Causes of Morbidity (V, W, X, or Y Codes) **Situational**
Required if the principal diagnosis is trauma.

73. Reserved for National Assignment by NUBC **Not Used**

74. Principal Procedure Code and Date **Not Used**

74 a-e. Other Procedure Codes and Dates **Not Used**

75. Reserved for National Assignment by the NUBC **Not Used**

76. Attending Provider Name and Identifiers **Required**

Enter the attending practitioner's last and first name.

Effective 01/01/2012, enter the National Provider Identifier (NPI) of the attending practitioner.

77. Operating Physician Name and Identifiers **Not Used**

78-79. Other Provider Name and Identifiers **Not Used**

80. Remarks Field **Situational**

Use to explain unusual services and to document medical necessity, for example, when unit limitations are exceeded, and for ambulatory room and board services.

81. Code-Code Field **Situational**

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.

81cc.a Taxonomy Code of the Billing Provider **Required**

Effective 01/01/2012, enter the 10-digit Taxonomy Code of the Billing Provider, as reported to Nebraska Medicaid.

81cc.b. ZIP CODE of the Billing Provider **Required**

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