Provider Bulletin 24-22A

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To:	All Providers Participating in the Nebraska Medicaid Program
From:	Drew Gonshorowski, Director
Date:	June 15, 2026
Re:	Coverage for Interpretation Services

This provider bulletin is being issued to update Provider Bulletin 24-22. Provider Bulletin 24-22 notified Nebraska Medicaid providers that Nebraska Medicaid reimburses interpretation services, effective for service dates on or after July 1, 2024. Implementation formally occurred on November 6, 2024. Interpretation Services provide support and ensure accuracy while Medicaid beneficiaries receive covered Medicaid services.

Updates

This provider bulletin provides updates information on interpretation service reimbursement since the initial publication of Provider Bulletin 24-22 in 2024. The information in this document reflects the current guidance as of the date of this bulletin. However, it is important to note that updated guidance in this bulletin (addressing hospital and CCBHC interpretation service reimbursement) apply retroactively for claims still within their timely filing limit.

Provisions of Service Delivery

Nebraska Medicaid will reimburse for Sign Language, Oral Interpretive, and Interpretation Services provided on or after July 1, 2024. Reimbursement will be made to appropriately enrolled Medicaid providers who supply the service at the same time as the covered healthcare service.

- Interpretation will only be covered when an additional cost is incurred from any of the following sources:
  - A staff member of the Billing Provider (see further below);
  - An individual/agency who is contracted with the Billing Provider (see further below);
  - An interpretation phone service contracted with the Billing Provider; or
  - Equipment that provides translation and interpretation support, such as Communication Access Real-Time Translation (CART)

Interpretation charges will not be paid when the service provider does not incur an added cost to provide the service. Examples include, but are not limited to, interpretation provided by the service recipient's family/friends, bilingual/ASL-trained provider staff who are directly providing the covered Medicaid services, or through free software programs such as Google Translate. Office staff who are not part of providing the direct covered services or contracted services retained by the provider strictly to provide interpretation services are permissible sources for payment.

Enrollment Requirements

Certified community behavioral health centers (CCBHC), federally qualified health centers (FQHC), rural health clinic (RHC), Tribal clinic and Tribal hospital clinic providers must use an existing "Professional Clinic" enrollment or separately enroll as a "Professional Clinic" provider type with the "All Other" provider specialty and the Interpreter (171R00000X) taxonomy. Either the existing or the new Professional Clinic enrollment must also add/affiliate with the **generic "group member"** below. This group member will be the only affiliated member and must be used as the service rendering provider on their professional claims.

Use the information below in the Maximus Provider Data Management System to find and affiliate the group member that is required for billing. Please contact Maximus at 1-844-374-5022 for assistance.

Generic Individual Group Member for Interpretation/Translation Claim:

First Name: Translator
Last Name: Interpreter
NPI: 3725164370
SSN: 100000000
Taxonomy: 171R00000X – Interpreter

For all other billing provider types, no additional provider agreement action should be necessary.

If a new provider agreement with Nebraska Medicaid is issued, please contact the managed care organizations (MCOs) to contract or credential the new enrollments for interpretation services. Questions about your Medicaid enrollment can be directed to Maximus at 1-844-374-5022 or NebraskamedicaidPSE@maximus.com.

Submitting Claims

Sign Language, Oral Interpretive, and Translator Services are covered under **HCPCS code T1013** at a rate of $13.50, per 15 minutes. The reimbursement of these services can be billed for no more than 2 hours (or 8 units) per day per client in non-facility and clinic settings. Residential/facility setting-based providers may bill for additional units more than 2 hours per day as deemed necessary during covered healthcare service delivery throughout the facility stay. Please refer to the list in **Appendix A** for a list of provider types considered to be residential or facility-based for the purpose of billing for interpretation services.

Provider types that bill on a practitioner claim or an 837P (Professional)/CMS 1500 can bill for interpretation services on the same claim as their standard charges.

Please consult the chart on the next page to determine how to bill for Interpretation services.

Provider Type	Bill T1013 on separate CMS 1500 Professional claim	Bill T1013 on separate UB-04 Institutional claim	Provider Specific Directions
Certified Community Behavioral Health Clinic (CCBHC)			Must use an existing professional clinic enrollment or create a professional clinic enrollment as noted above and must affiliate/add the generic individual group member. Do not use the CCBHC billing NPI to submit interpretation services for payment. Each claim must list the generic individual group member as the service rendering provider. Interpretation should be billed on the CMS 1500 form using their professional clinic provider agreement. **IMPORTANT: If the CCBHC included interpretation costs in its cost report for the development of CCBHC encounter rates, CCBHCs are not eligible for a separate interpretation payment.**
Indian Health Hospital Clinic	Y	N	Must use an existing professional clinic enrollment or create a professional clinic enrollment as noted above and must affiliate/add the individual generic group member. Each claim must list the generic individual group member as the service rendering provider. Interpretation should be billed on the CMS 1500 form using their professional clinic provider agreement.
Tribal 638 Clinic	Y	N	Must use an existing professional clinic enrollment or create a professional clinic enrollment as noted above and must affiliate/add the generic individual group member. Each claim must list the generic individual group member as the service rendering provider. Interpretation should be billed on the CMS 1500 form using their professional clinic provider agreement.
Federally Qualified Health Center	Y	N	Must use an existing professional clinic enrollment or create a professional clinic enrollment as noted above and must affiliate/add the generic individual group member. Each claim must list the generic individual group member as the service rendering provider. Interpretation should be billed on the CMS 1500 form using their professional clinic provider agreement.

Provider Type	Bill T1013 on separate CMS 1500 Professional claim	Bill T1013 on separate UB-04 Institutional claim	Provider Specific Directions
Rural Health Clinic	Y	N	Must use an existing professional clinic enrollment or create a professional clinic enrollment as noted above and must affiliate/add the generic individual group member. Each claim must list the generic individual group member as the service rendering provider. Interpretation should be billed on the CMS 1500 form using their professional clinic provider agreement.
Pharmacy	Y	N	Use existing Pharmacy enrollment to bill T1013 on a CMS 1500 claim.
Long Term Care Facilities (ALF, NF, ICF, Hospice in NF)	Y	N	Use existing enrollment to bill the T1013 on a CMS 1500 claim. Please note: If the member's NF stay is covered by the MCO, bill interpretation during the covered MCO stay to the MCO. All other NF days not covered by the MCO (along with ALF/ICF and Hospice in NF/ICF) are to be billed directly to FFS Medicaid.
Home Health Agency	N	Y	Use existing enrollment to bill T1013 on a separate UB-04 claim, which will be separate from the HHA services claim. Use revenue code 969 (Other Professional Services) and the standard HHA bill type to bill for interpretation services.

Provider Type	Bill T1013 on separate CMS 1500 Professional claim	Bill T1013 on separate UB-04 Institutional claim	Provider Specific Directions
Hospitals (APR DRG and EAPG)	N	N	• Use existing enrollment. When interpretation is provided in an INPATIENT SETTING, submit a separate Outpatient claim using bill type 13X. Revenue code 969 (other professional services) should be used. Interpretation services should be the only service billed. The hospital may elect to bill for the entire duration of the inpatient stay on one claim with separate lines for each date of service and total units or may also elect to split out onto multiple claims covering the length of stay. In either case, the claim(s) must align with the inpatient stay dates. • When interpretation is provided in an OUTPATIENT SETTING, the hospital will submit interpretation on the SAME claim as their other standard outpatient charges. The hospital will use revenue code 969 for interpretation charges along with the standard bill type. For both the inpatient and outpatient setting interpretation, the claim will pay at the same quarter hour rate as described in the provider bulletin ($13.50).
Hospitals (CAH, REH, Rehab, Psych, LTACH)	N	N	Use existing enrollment. For both IP and OP-based interpretation, the hospital will submit a separate Outpatient claim with bill type 13X using revenue code 969. A hospital may elect to bill for the entire duration of the inpatient stay interpretation onto one claim with separate lines for each date of service and total units or may also elect to split out onto multiple claims covering the length of stay. Reimbursement will follow the same quarter hour rate as described in the provider bulletin ($13.50).

All other providers not named in the table will submit interpretation charges with their existing covered services claim.

If your existing, covered charges include an attending/ordering/referring/prescribing individual provider name and NPI on the claim, it will be necessary for you to include this same information when billing for interpretation services. For provider types noted above, which are filing a separate professional or institutional claim, you will need to use the same attending/ordering/referring/prescribing provider as you would on your services claim.

Rule of 8's: The rule of 8's will be followed for billing quarter-hour units. The Rule of 8's is defined as providing at least 8 minutes of service to bill for a quarter hour/15-minute period. For example, if 8 minutes of interpretation are provided, the provider can bill for 1 unit of service. Or if at least 23 minutes of interpretation are provided, the provider can bill for 2 units of service.

Documentation

Interpretation services must be documented in the patient's record and must include:

- The service date and specific beginning and end times;
- The name of the translator/interpreter and the organization with which the translator/interpreter is associated and the type of service provided;
- The method of interpretation (e.g.: in person or via phone); and,
- A general description of the medical service the client received.

When supplied as part of a visit via telehealth, the patient's record must reflect the requirements for telehealth and interpretation.

Documentation that is kept on the patient's record must demonstrate the relationship of the translator/interpreter to the Billing Provider.

When submitting claims, providers must maintain documentation and be able to provide copies to Nebraska Medicaid and/or their contractors upon request. Documentation must include information on the service provided. An example of this is as follows:

- *July 5, 2024: 10:00 pm to 10:30 pm John Doe supplied Spanish interpretation in the emergency department to patient Sam Smith who was receiving care for a hand injury requiring stitches and a burn.*

Provider Resources

If you have questions regarding this bulletin, please email DHHS.HeritageHealth@nebraska.gov. Health plans should also copy their contract manager.

Provider bulletins, such as this one, are posted on the DHHS website at https://dhhs.ne.gov/pages/Medicaid-Provider-Bulletins.aspx. Please subscribe to the page to help you stay up to date about new provider bulletins.

APPENDIX A: Facility Billing Provider Types

Adult Substance Abuse (provider type 48, specialty 26)
Ambulatory Surgical Centers
Assisted Living Facilities
Day Rehabilitation
Day Treatment
Dialysis Centers
Home Health
Hospice
Hospice provided in Nursing Facilities and Intermediate Care Facilities
Hospitals (all types, including Indian Health)
Intermediate Care Facilities
Licensed Mental Health Clinic (provider type 12, specialty 26)
Medically Monitored Inpatient Withdrawal (MMIW)
Nursing Facilities
Opioid Treatment Program (OTP)
Psychiatric Residential Treatment Facilities (PRTF)
Residential Rehabilitation
Therapeutic Group Home
Substance Abuse Treatment Center (provider type 47, specialty 26)