471-000-59 Nebraska Medicaid Billing Instructions for Completing Form MC-82N, "Private Duty Nurse Claim Form" for Private Duty Nursing 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 private duty nursing services are covered in 471 NAC 13-000.

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 or 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 explanation of benefits, 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.

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: Private Duty Nursing 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: Private Duty Nursing services are billed to Nebraska Medicaid on Form MC-82N, "Private Duty Nurse Claim Form". Instructions for completing Form MC-82N begin on page 2 in 471-000-59. MC-82N Forms may be obtained from the DHHS website at: https://public-dhhs.ne.gov/Forms/Default.aspx

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 HHS 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.

MC-82N FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims on Form MC-82N, retain a duplicate copy and mail the ORIGINAL 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 Form Completion Instructions: Private-duty RN's and LPN's complete one copy of Form MC-82N as follows:

1. PATIENT'S NAME: Enter the client's full name.

2. PATIENT'S MEDICAID NUMBER: Enter the client's complete eleven-digit identification number (Example: 123456789-01).

3.a. REFERRING PHYSICIAN'S NAME: Enter the name of the client's doctor.

3.b. REFERRING PHYSICIAN'S NPI: Effective 01/01/2012, enter the National Provider Identifier (NPI) of the referring physician.

4. ICD INDICATOR: Check one of the ICD boxes.

5. Primary DIAGNOSIS: Write the client's diagnosis. This is found in Item #9 of the Form MS-81, "Certification and Plan of Care for Private Duty Nursing."

6. DATE OF SERVICE: Enter 8-digit numeric dates of service (Example: From: 04082004 To: 04112004). Do not bill more than one week per line.

   PROCEDURE CODE: Enter the appropriate procedure code (See 471-000-513 Nebraska Medicaid RN/LPN Fee Schedule for procedure codes).

   DX CODE: Enter the ICD-CM diagnosis code found in Item #9 of the Form MS-81. For dates of services on or before September 30, 2015 only ICD codes will be accepted on this form. For dates of service on or after October 1, 2015 only ICD-10 codes will be accepted.

CHARGES: Total billed per line. This is the unit rate times the number of units being billed.

UNITS: Enter the number of units billed for the dates of service per line. If the procedure code description includes specific time increments, they should be billed as one unit of service.

For procedure codes T1000 TD, T1000 TE, T1002, and T1003 report the units using the following table:

Unit	Time	Unit	Time
1	8-22 minutes	4	53-67 minutes
2	23-37 minutes	5	68-82 minutes
3	38-52 minutes	6	83-97 minutes, etc.

For procedure codes S5105 and S5105 TD use 1 unit for each day of service. The maximum units are 6 per week.

For procedure codes T1024 and T1024 TG for services provided under contract where the medical day care ‘encounter’ is defined as **‘per hour’ or ‘full day’ care** report units as follows:

When less than 5 hours of service is provided, report the unit of service as ‘1’ through ‘4’ to specify the actual number of hours of care provided. When between 5 and 12 hours (full day) of care is provided, report the unit of services as ‘5’. Use procedure code modifier TG to indicate complex medical day care. Each day of care must be billed on a separate claim line.

For procedure codes T1024 and T1024 TG for services provided under contract where the medical day care ‘encounter’ is defined as **‘4 hours’ of care** report units as follows:

Report one unit of service for each 4-hour block of time care is provided. Use procedure code modifier TG to indicate complex medical day care. Each day of care must be billed on a separate claim line.

PRIOR AUTHORIZATION NUMBER: Enter the prior authorization number obtained from the authorizing agency. The dates of service billed must correspond with the covered period of the authorization. The prior authorization number is found in Item #23 of the Form MS-81.

7. TOTAL CHARGES: Add the charges and enter the total.
8. AMOUNT PAID BY/DUE FROM PATIENT: Enter the amount the client paid or must pay for the services on this claim. Contact the client’s worker for this information.
9. BALANCE DUE: Subtract #7 from #6 and enter the amount in this field.
10. DATE: Enter the date this form is being completed.
11. SIGNATURE: Sign the form. Read the “signature of provider” statement before signing the form.

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

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

14. PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER: Complete as indicated, including the nine-digit Zip Code (Zip+4) of the Billing Provider, as reported to Nebraska Medicaid.

To view printable form, click here: Private Duty Nurse Claim Form

Division of Medicaid and Long-Term Care

Private Duty Nurse Claim Form

1. Patient's Name:
2. Patient's Medicaid Number: ID #:
3. Referring:
   a. Physician's Name:
   b. Physician's NPI:
4. ICD Indicator
   ☐ ICD-9 ☐ ICD-10
5. Primary Diagnosis Code:

6	Date of Service		Place of Service	Procedure Code	DX Code	Charges	Units	Prior Authorization Number
	From:	To:						
A			12					
B			12					
C			12					
D			12					
E			12					
F			12					
			7. Total Charges					
			8. Amount Paid By / Or Due From Client					
			9. Balance Due					

SIGNATURE OF PROVIDER: I certify that (1) the services listed on this claim were medically indicated and necessary to the health of this patient and were personally rendered by me; (2) the charges for such services are just, unpaid, actually due according to law and program policy and not in excess of regular fees and, that no charge, in addition to line 7, will be made; (3) the information provided on this claim is true, accurate and complete. I agree to comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I understand that payment and satisfaction of this claim will be from Federal and/or State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

10. Date

11. Signature of Provider
    SIGN HERE

Mail to:

DHHS - 5th Floor
PO Box 95026
Lincoln, NE 68509-5026
Attention: Medicaid Claims Unit

12. Provider NPI: Taxonomy:
13. Provider Name:
    Address:
    City: State Zip +
    Telephone Number (include area code)

If New Address ☐ check here Starting Date:

Distribution: Part One - DHHS Medicaid Payments; Part Two - Provider Copy

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(Previous Version 12/11 should NOT be used)