

471-000-62 Nebraska Medicaid Billing Instructions for Physician, Laboratory, and Ambulatory Surgical Center (ASC) 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.

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.

Medicaid regulations for physician services are in 471 NAC 18-000. Medicaid regulations regarding HEALTH CHECK (EPSDT) services are covered in 471 NAC 33-000. Medicaid regulations regarding ambulatory surgical centers are covered in 471 NAC 26-000. Medicaid regulations regarding federally qualified health centers (FQHC's) are covered in 471 NAC 29-000. Medicaid regulations regarding non-rural health clinic services provided by rural health clinics (RHC's) are in 471 NAC 34-000.

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 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.

4. The Internet. Separate login IDs and passwords are required for each person accessing the site. For enrollment forms, go to Internet Access for Providers or call the Medicaid's EDI Help Desk at 866-498-4357 (in Lincoln, 402-471-9461).

CLAIM FORMATS

Electronic Claims: Physician, laboratory, and ambulatory surgical center (ASC) 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: Physician, laboratory, and ambulatory surgical center (ASC) 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 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 the Lincoln area) 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 Web site 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.

Specific billing instructions for the following special services begin on page 8 of these instructions:

Allergy	Nursing Home Exams
Ambulatory Surgical Centers	Post-Operative Care
Anesthesiology	Radiology
Assisting at Surgery	Supply Services
Bilateral Surgical Procedures	Telehealth Services
HEALTH CHECK (EPSDT)	Tribal (638) Clinic Services
Injections	Unborn services
Laboratory Services	Vaccine
Multiple Procedures	Visual Care Services
Nurse-Midwife/Nurse-Practitioner Services	Waiver Physicals

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 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: For consultations, enter the name of the referring/prescribing physician/practitioner.
- 17a. OTHER ID#: Leave qualifier field blank. Effective 01/01/2012, this field is no longer required.
- 17b. NPI#: Effective 01/01/2012, enter the National Provider Identifier (NPI) of the referring practitioner.

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 date 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.

Note: For ambulatory surgical center services, enter the date of the ASC surgery related to ASC services being billed.

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

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

20. OUTSIDE LAB: Leave blank.

CHARGES: Leave blank.

- *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.

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 services 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.

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.

23. PRIOR AUTHORIZATION NUMBER: If billing for services that require prior authorization, submit a copy of the approval documentation issued by the Department with the claim only if instructed to do so as part of the authorization notification. See 471 NAC 18-004.01 for regulations on prior authorization of physician services. For clinical laboratory services, enter the ten-digit CLIA number.
- *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 8-digit numeric date of service rendered. Each procedure code/service billed requires a date. Each service must be listed on a separate line. The "From" date of service must be completed. The "To" date of service may be left blank. If billing for CONSECUTIVE days at the same care level, claims must state the beginning (under "From") and ending date (under "To").
- *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 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
 - 10 Telehealth Provided in a Patient's Home
 - 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

Exception for Laboratory Billing:

If the physician is billing for a lab service performed in his/her own office, use the appropriate code for the physician's office (11).

If the physician (with a specialty of pathology) is billing for a test on a sample received from an inpatient, outpatient, or physician's office, use the appropriate code designating place of service as independent laboratory (81).

If an independent laboratory is drawing a sample in its own laboratory, use the appropriate code for independent laboratory (81).

If an independent laboratory is billing for a test on a sample drawn on a hospital inpatient, use the appropriate code for independent laboratory (81).

If an independent laboratory is billing for a test on a sample drawn in a physician's office, use the appropriate code for independent laboratory (81).

- *24D. PROCEDURES, SERVICES, OR SUPPLIES: In the unshaded area, enter the appropriate CPT or HCPCS Level II procedure code and, if required, procedure code modifier. Procedure codes used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-518, 471-000-533, and 471-000-540). Up to four modifiers may be entered for each procedure code. 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 1/2 x 11 attachment to the claim.

For physician administered drugs, other than vaccines, enter the National Drug Code (NDC) in the upper shaded area of lines using HCPCS or CPT codes for a drug (24D through 24H).

For all physician administered drugs for which the billed amount is \$500 or more, submit a copy of the invoice. This pricing will be entered onto the provider charge screen and another invoice will not be needed until there is a price change.

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. Note: For ambulatory surgical center services, do not itemize services included in the ASC facility fee.

*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.

24H. **EPSDT/FAMILY PLAN:** In the unshaded area, enter the last digit of appropriate HEALTH CHECK (EPSDT) referral indicator code (AV, S2, NU, and ST) with CPT well-child preventive procedure codes 99381-99395 with the required the EP modifier (e.g. 99282-EP). See HEALTH CHECK billing instructions on page 11.

*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, this 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 insurance remittance advice, explanation of benefits, denials 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.
32. SERVICE FACILITY LOCATION INFORMATION: For mileage, enter the point of origin and final destination. For services provided to a client residing in a nursing facility or ICF/MR, enter the name of the facility. For services provided in a hospital, clinic, lab, ambulatory surgical center, enter the name and address of the facility.
- 32a. NPI#: Not used.
- 32b. OTHER ID #: Not used.
- *33. BILLING PROVIDER INFO & PH#: 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.

SPECIFIC BILLING INSTRUCTIONS

ALLERGY: For allergy testing, enter the exact number of tests performed. See CPT procedure manual instructions. For example, if 15 percutaneous tests are done under CPT code 95004, enter "15" in field 24G – "days or units". Allergy therapy will also follow the CPT instructions. Bill number of vials or doses per CPT instructions.

AMBULATORY SURGICAL CENTERS: NMAP covers facility services for the surgical procedures on Medicaid's list of covered ASC procedures. For regulations on ambulatory surgical centers see 471 NAC 26-000.

For the facility fee, enter the appropriate CPT code for the approved surgical procedure with modifier "SG". For dental services, use CPT procedure code 41899 with modifier "SG". Do not itemize services included in the facility fee. Laboratory services performed outside of the ASC by an independent or hospital laboratory must be claimed by the independent or hospital laboratory which performed the lab work.

For durable medical equipment over and above items included in the facility fee, non-routine x-rays, or non-routine laboratory services (only if certified as an independent lab – 471 NAC 26-003.04), enter the appropriate HCPCS code.

ANESTHESIA SERVICES: Enter the anesthesia CPT procedure code (00100-01999) and modifier, if appropriate.

When a physician bills for anesthesia services, the correct procedure code and modifiers indicate that –

1. Services were personally provided by the physician to the individual patient - No modifier is needed; or
2. The physician provided medical direction for CRNA services and the number of concurrent services directed. The following modifiers must be used by the anesthesiologist when claiming medical direction of CRNA's:

AA – Anesthesia services performed personally by anesthesiologist; or

QY – Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist

Note: This is paid as a physician service. If both a CRNA and an anesthesiologist are involved in the same procedure, only the anesthesiologist is paid.

QK – Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals

Claims for these services must indicate actual time in one-minute increments in Field 24 G. All claims must be one-line claims. (For example, when Field 24 D, description of service, indicates **"1" hour and 30 minutes**, Field 24 G should be **90**). The physician's personal services, up to and including induction, are considered the professional component. For induction only, the physician claims only one unit of anesthesia.

Anesthesia time begins when the anesthesiologist is personally in control of the patient in the operating room or equivalent area, and ends when the patient may be safely placed under post-operative supervision and the physician is no longer in attendance.

Medicaid does not make additional reimbursement for risk or emergency factors.

Certified Registered Nurse Anesthetists (CRNA's): Enter the anesthesia procedure code (00100-01999). The CRNA may bill directly, or through the physician employer or hospital (all must billed on Form CMS-1500 or standard electronic transaction (ASC X12N 837). Exception: Rural hospitals that have been exempted by their Medicare intermediary for CRNA billing must follow the Medicare billing requirements.

The following modifiers must be used by CRNA's when claiming anesthesia services:

QX – CRNA service: with medical direction by a physician

QZ – CRNA service: without medical direction by a physician

Claims for these services must indicate actual time in one-minute increments in Field 24 G. For example, when Field 24 D indicates “**1 hour and 30 minutes,**” Field 24 G should be **90**.

Anesthesia time begins when the CRNA's personally in control of the patient in the operating room or equivalent area, and ends when the patient may be safely placed under post-operative supervision and the CRNA is no longer in attendance.

ASSISTING AT SURGERY: Enter the appropriate procedure code with modifier “80” (for example, 47600-80, cholecystectomy assist).

BILATERAL SURGICAL PROCEDURES: Enter the appropriate CPT procedure code with modifier “50” on a single line of service. Enter ONE CHARGE in field 24F (\$ charges). Enter “1” in field 24G (days or units).

HEALTH CHECK (EPSDT) Preventive Care for Persons under 21:

Purpose: The HEALTH CHECK program is to provide children the opportunity for achieving and maintaining their optimal health status by (1) educating families about the benefits of preventive health care through regular screening examinations, (2) identifying the need for follow-up care for conditions detected during the health screening, and/or (3) referring and providing necessary treatment.

Screening Providers: Health screening services are to be performed by or under the supervision of a physician. Family and pediatric nurse practitioners and physician assistants may perform HEALTH CHECK services according to their scope of practice under state and federal regulations. Special services such as nutritional counseling, childbirth education, and other risk reduction services are to be provided by practitioners according to 471 NAC 33-003.

Periodicity Schedule: The recommended frequency of health screening examinations is the current American Academy of Pediatrics schedule for health supervision visits. Exams may be done more frequently if a problem is suspected or a problem has worsened. Children under the jurisdiction of the Department (e.g. foster care, state wards) may be screened each time they are placed in a foster home or facility.

Health Screening Components (see 471 NAC 33-002 for definitions):

Health and developmental history (incl. Nutritional assessment)

Unclothed physical examination

Health education (anticipatory guidance)

Immunization assessment and update

Laboratory tests (as appropriate for age and population group. Include lead level assessment and testing)

Visual screening (by screening physician or by referral to eye doctor)

Hearing screening (by screening physician or by referral to certified audiologist)

Dental screening (visual inspection for children under 12 months by screening physician, by referral to a dentist following the eruption of the first tooth, but not later than 12 months of age)

Billing: All scheduled well baby/child, health supervision, and comparable examinations for individuals under 21 are to be billed as HEALTH CHECK examinations. Physical examinations for school, camp, and school activities may be covered as HEALTH CHECK examinations if the required components are performed. Interperiodic screening examinations performed outside of the periodicity schedule that do not include the minimum components of a HEALTH CHECK examination but rather are performed to evaluate symptoms, must be billed as acute care services.

Procedure Codes:

The CPT procedure codes 99381-99385 and 99391-99395 with modifier “EP” **must** be used to report and claim all HEALTH CHECK and well baby/well child visits on electronic 837 practitioner claims or on Form CMS-1500 (for example 99392 EP). Refer to the Nebraska Medicaid Practitioner Fee Schedule for HEALTH CHECK Services at 471-000-533 for procedure codes and modifiers.

Federally Qualified Health Centers must use procedure code T1015 on the first line of the claim for HEALTH CHECK (EPSDT) services on the CMS-1500. Procedure codes for services rendered during the encounter are to be billed on subsequent claim lines (for example, T1015 on line 1, 99383-EP on line 2 and 90707-SL on line 3).

HEALTH CHECK (EPSDT) Referral Indicators Codes:

One of the following referral indicator codes **MUST** be included on claims using CPT well-child preventive procedure codes 99381-EP through 99395-EP (Electronic 837P or CMS 1500 box 24H). Enter the last digit of the appropriate HEALTH CHECK (EPSDT) referral indicator listed below:

AV = **V** Patient refused referral;

S2 = **2** Patient is currently under treatment for referred diagnostic or corrective health problems;

NU = **U** No referral given; or

ST = **T** Referral to another provider for diagnostic or corrective treatment.

PHYSICIAN ADMINISTERED DRUGS: Code claims for drugs administered in the clinic and out-patient hospital setting as follows:

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.	
From To						PLACE OF		(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS OR	EPST OR	ID.	RENDERING	
MM	DD	YY	MM	DD	YY	SERVICE	ENG	CPT/HCPCS	MODIFIER	POINTER		UNITS	Family Plan	QUAL	PROVIDER ID. #	
N400026064871 Immune Globulin Intravenous UN2														N	1B	12345678901
10	01	05	10	01	05	11		J1563		13	500.00	20	N	NPI	0123456789	

Only one NDC and a single HCPCS or CPT code may be added on each line of the claim.

- For childhood immunizations, see Vaccine section.

LABORATORY SERVICES: Do not bill for a lab test performed outside the physician's office. Use procedure code 36415 for venipuncture collection. Use procedure code 51701 - 51702 for urinary catheterization. Routine capillary blood collection (i.e., finger sticks or heel sticks) and urine sample collection are not separately reimbursed. The professional component is allowable only for anatomical pathology services and consultative pathology services.

For laboratory services performed in a physician's office, use the appropriate CPT code for the service.

- Use the unmodified code when the physician performs both the professional and technical components.
- Use modifier 'TC' when the technical component is performed at the physician's office or a laboratory center and the professional component (i.e., interpretation and report) is provided by an outside source. The professional component must be billed by the provider of the service.
- When the physician performs only the professional component (i.e., interpretation and report), use modifier '26' if the CPT procedure code description includes both the technical and professional components.
- Do not use modifier '26' if the CPT procedure code description specifies only the professional component.

MULTIPLE PROCEDURES: Enter the appropriate CPT procedure code and, if applicable, modifier, for each service.

NURSE MIDWIFE/NURSE PRACTITIONER SERVICES: Claims for nurse midwife and nurse practitioner services must be filed on Form CMS-1500 separate from the physician's services if enrolled under the physician's provider agreement. The nurse midwife/nurse practitioner's social security number is required in Field 25 as the service rendering provider.

NURSING FACILITY EXAMS: Use the appropriate CPT procedure codes:
Annual nursing facility physical - 99318

PRIMARY CARE PHYSICIAN (PCP) CASE MANAGEMENT FEE: For physicians participating in the Nebraska Health Connection Medicaid managed care plan Primary Care + network, HCPCS code G9008 only appears on the Nebraska Medicaid remittance advice to indicate the primary care case management service. Do not submit this procedure code on claims to Nebraska Medicaid.

POST-OPERATIVE CARE: Nebraska Medicaid payment for surgical procedures includes 14-day post-operative care. Post-operative care will not be reimbursed separately unless the surgery claim was submitted with modifier “54” indicating surgery only. When a surgical procedure and post-operative care are not performed by the same practitioner, submit the post-operative care using the appropriate CPT procedure code (evaluation and management codes) for the service provided. Do not use the surgical procedure code with the modifier “55”. For claims submitted for surgery only with no pre- or post-operative care use the appropriate CPT code and modifier “54”. Evaluation and management (E&M) services provided by the surgeon during the 14-day post-op period, that pertain to the surgery, are included in the global surgery package. However, E&M services performed during the postoperative period for a reason unrelated to the original procedure are separately payable and must be billed by adding a 24 modifier to the appropriate level E&M service.

RADIOLOGY SERVICES: For radiology services performed in a physician’s office, use the appropriate CPT code for the service.

- Use the unmodified code when the physician performs both the professional and technical components.
- Use modifier "TC" when the technical component is performed at the physician's office or radiology center and the professional component (i.e., interpretation and report) is provided by an outside source. The professional component must be billed by the provider of the service.
- When the physician performs only the professional component (i.e., interpretation and report), use modifier "26" if the CPT procedure code description includes both the technical and professional component.
- Do not use modifier "26" if the CPT procedure code description specifies only the professional component.

SUPPLY SERVICES: For items such as orthopedic supplies, dressing supplies, straps, splints, etc., use appropriate HCPCS procedure codes, or CPT 99070 with a description of the supply when there is no appropriate code. Attach a copy of the invoice to these claims.

The ONLY supplies covered as “physician services” are supplies that require application by the physician or physician staff. Supplies that are taken home for the Medicaid client to use at a later time are not reimbursable as “physician services”. The Medicaid client must obtain take-home supplies from an independent supplier who is enrolled in the Medicaid program to bill for supplies.

TELEHEALTH SERVICES: Medicaid regulations regarding telehealth services are 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.

TRIBAL (638) CLINIC SERVICES: Most office visit services performed at tribal (638) clinics are to be billed as encounter visits and paid at an encounter rate established by CMS. An encounter means a face-to-face contact between a health care professional (e.g. physician, physician assistant, nurse practitioner, podiatrist, optometrist, and pharmacist) and an IHS beneficiary eligible for Nebraska Medicaid for the provision of Medicaid-defined services in a tribal (638) facility within a 24-hour period ending at midnight, as documented in the client's medical record. The encounter includes the practitioner's visit, radiology procedures, laboratory services, supplies, and medications used in conjunction with the visit. The HCPCS code used to bill the encounter is T1015 SE.

T1015 SE- Clinic Visit/Encounter, all-inclusive (non-dental) – Procedure code modifier "SE" is required for this service. Procedure code T1015 SE must be billed on the first line of the Form CMS-1500. Actual procedure codes for services rendered during the encounter are to be billed on subsequent claim lines. Only the encounter line will be paid. (For example, Line 1 is T1015 SE, line 2 is 99213 (or 99382 EP if HEALTH CHECK (EPSDT), line 3 is 71070, and line 4 is 81000).

Services rendered outside the office setting, office services that do not meet the criteria for the encounter, or services provided to non-American Indian or non-Alaskan Native clients are to be billed on the Form CMS-1500 using the appropriate HCPCS codes and will be paid according to the Nebraska Practitioner Fee Schedule. Examples of non-encounter services include, but are not limited to: Inpatient hospital visits, home and nursing facility visits, home health visit, durable medical equipment, ambulance, brief visit with nurse for blood pressure check, telehealth or telephone consultations.

UNBORN SERVICES: Pregnancy-related, postpartum, and family planning services are covered for (1) the eligible mother (pregnant woman) and her eligible unborn/newborn or as (2) the ineligible mother and her eligible unborn/newborn (See 471 NAC 18-004.48). When billing for services please note:

(1) **Eligible mother and her eligible unborn/newborn:**

- Each have their own Medicaid ID number. Use the mother's number to bill for the pregnancy-related services. Use the unborn/newborn's number to bill for the baby's services such as newborn hospital visits.
- Each is eligible for all Medicaid-covered services.

(2) **Ineligible mother and her eligible unborn/newborn:**

- The mother and her unborn/newborn share the same Medicaid ID number. The UNBORN child is the Medicaid eligible individual. In field 1, enter the Medicaid number of the unborn/newborn. In Field 2, enter the name of the mother. In field 3, enter the month, day, and year of birth of the mother. In field 4, enter "unborn" or the newborn child's name as it appears on the Nebraska Medicaid card or ID document.
- The mother is eligible for pregnancy related services during the pregnancy and until the end of the month in which the 60th postpartum day occurs.

VACCINE: Nebraska Medicaid pays only for the administration of vaccines available to providers through the Vaccine for Children Program (VFC). To bill for the administration of vaccine provided through the VFC Program, use the appropriate CPT code for the vaccine with an **SL** modifier. Charges should reflect the cost of administering the vaccine only.

- For immunizations not available through VFC, use the appropriate CPT immunization procedure code for the vaccine and the appropriate procedure code for the administration. The administration fee and cost of the vaccine must be billed separately. It is not necessary to submit the NDC for the vaccine.

VISUAL CARE SERVICES: Refer to the Medicaid Visual Care Provider Handbook at 471 NAC 24-000 for coverage policies and 471-000-524, Nebraska Medicaid Practitioner Fee Schedule for Visual Care Services, for procedure codes and modifiers.

WAIVER PHYSICALS: Routine medical assessments are not Medicaid covered services for adults, with the **exception** of adults with developmental disabilities who are applying for or receiving Home and Community Based Developmental Disabilities (HCB DD) Medicaid Waiver services. The client must be Medicaid eligible on the date the service is provided.

A form from the HCB DD caseworker should be forwarded to the physician's office indicating that the client is either applying for or receiving Medicaid Waiver services.

When submitting the claim for this medical assessment, the provider must indicate on the claim that the routine medical assessment was provided to an individual applying for, or receiving services from one of the HCB DD Medicaid Waivers for adults.