471-000-75 Nebraska Medicaid Billing Instructions for Completing Form MC-82-AD, "Adult Day Care Nursing/Aide Services Claim Form" for Private Duty Nursing or Personal Assistance Services in Adult Day Care Centers

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 or enrolled in the Nebraska Health Connection Medicaid managed care plan Primary Care +. Medicaid regulations for private duty nursing services are covered in 471 NAC 13-000 and for personal assistance services 471 NAC 15-000.

Claims for services provided to clients enrolled in a Nebraska Medicaid managed care health maintenance organization plan (e.g., Share Advantage) 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 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 monthly Nebraska Medicaid Card or Nebraska Health Connection ID Document. For explanation and examples, see 471-000-121;
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/personal care aide 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/personal care aide services are billed to Nebraska Medicaid on Form MC-82-AD, "Adult Day Care Nursing/Aide Services Claim Form". Instructions for completing Form MC-82-AD begin on page 2 in 471-000-75. MC-82-AD Forms may be obtained from the HHS local office.

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 local 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-82-AD FORM COMPLETION AND SUBMISSION

The HHS worker sends the provider copy to the aide and the agency copy to -

Medicaid Claims Processing
Health and Human Services Finance and Support
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 nurses (RN'S/LPN's) and personal assistants complete one copy of Form MC-82-AD (3 part) for each client as follows:

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

2. PATIENT'S CASE NUMBER AND ID#: Enter the client's complete eleven-digit identification number (Example: 9-digit case number, 123456789, and 2-digit ID#, 01). When billing for services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (see 471 NAC 2-006.06.) These numbers are on the client's Medicaid card or identification document.

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

3.b. REFERRING PHYSICIAN'S LICENSE NUMBER: Enter the physician's license number. The physician has this information.

4. PATIENT'S DIAGNOSIS: Write the client's diagnosis. The client's physician has this information.

5. 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, or 471-000-515, Nebraska Medicaid Personal Assistant Fee Schedule for procedure codes).

Procedure Codes for LPN Services

T1000 TE	Private duty/independent nursing service(s) – licensed, up to 15 minutes.
T1003	LPN/LVN services, up to 15 minutes.

Procedure Codes for RN Services

T1000 TD	Private duty/independent nursing service(s) – licensed, up to 15 minutes.
T1002	RN Services, up to 15 minutes.

Procedure Codes for Center-Based Day Care Services

S5105 TD	Day care services, center-based; services not included in program fee, per diem.(RN service).
S5105	Day care services, center-based; services not included in program fee, per diem.

Procedure Codes for Contracted Medical Day Care Services where the medical day care 'encounter' is defined as **"per hour'** or **'full day'** care (See DAYS for unit instructions.):

T1024	Evaluation and treatment by an integrated specialty team contracted to provide coordinated care to multiple and severely handicapped children, per encounter.
T1024 TG	Evaluation and treatment by an integrated specialty team contracted to provide coordinated care to multiple and severely handicapped children, per encounter. Procedure code modifier TG (high tech) is required.

Procedure Codes for Contracted Medical Day Care Services where the medical day care 'encounter' is defined as **"4 hours'** of care (See DAYS for unit instructions.):

T1024	Evaluation and treatment by an integrated specialty team contracted to provide coordinated care to multiple and severely handicapped children, per encounter.
T1024 TG	Evaluation and treatment by an integrated specialty team contracted to provide coordinated care to multiple and severely handicapped children, per encounter. Procedure code modifier TG (high tech) is required.

DX CODE: Leave blank.

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

DAYS: Enter the number of units billed for the dates of service per line. See 471-000-513, Nebraska Medicaid RN/LPN Fee Schedule, or 471-000-515, Nebraska Medicaid Personal Assistant Fee Schedule for procedure code information.

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

Unit	Time	Unit	Time
1	1-15 minutes	4	46-60 minutes
2	16-30 minutes	5	61-75 minutes
3	31-45 minutes	6	76-90 minutes

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 where the 'encounter' is 'per day' or 'full day' care: 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 where the 'encounter' is '4 hours' of care: 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.

6. TOTAL CHARGES: Add the charges and enter the total.

7. AMOUNT PAID BY/DUE FROM CLIENT: Enter the amount the client paid or must pay for the services on this claim. Contact the client's worker for this information.

8. BALANCE DUE: Subtract #7 from #6 and enter the amount in this field.

9. SERVICE RENDERING PROVIDER NUMBER: Enter the Social Security Number of the individual who provided the service (RN, LPN, or aide).

10. DATE: Enter the date this form is being completed.

11. SIGNATURE: Signed by authorized entity of the Adult Day Care Center. Read the "signature of provider" statement before signing the form.

12. PROVIDER NUMBER: Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (example 123456789-12).

13. PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER: Complete as indicated.

NOTE: After completing items 1-13, the provider sends all three parts of Form MC-82-AD to the client's worker at the HHS local office. The HHS worker completes the section, "Local Office Use Only," by entering the number of units authorized for this billing period and the amount paid bay other sources for this claim. After signing and dating the claim, the worker sends the agency (top) copy of the form to the Central Office for processing and the provider (last-white) copy to the personal assistant. The HHS worker keeps the HHS local office (middle-white) copy for the client's record.

Nebraska Department of Health and Human Services
ADULT DAY CARE NURSING/AIDE SERVICES CLAIM FORM

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

1. Patient's Name _____

2. Patient's Case Number _____ I.D. # _____

3. a. Referring Physician's Name _____

   b. License Number _____

4. Patient's Diagnosis _____

5.	Date of Service From:	Date of Service To:	Place of Service	Procedure Code	DX Code	Charges	Units
A			33				
B			33				
C			33				
D			33				
E			33				
F			33				
				6. Total Charges			
				7. Amount Paid by or Due from Client			
				8. Balance Due			
				9. Service Rendering Provider Number			

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 6, 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**

LOCAL OFFICE USE ONLY

Number of units authorized for billing period _____

❑ Central Office Approved

POS _____

Signature

Date

12. Provider Number _____ - _____

13. Provider Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number ( ) _____

❑ If New Address, (check here), - Starting Date _____

Distribution:
HHS Medical Payments - BLUE Copy;
Local Office - YELLOW Copy;
Provider - WHITE Copy.

MC-82AD Rev. 3/04 (56042)
(Previous version 5/99 should NOT be used)