471-000-80 Nebraska Medicaid Long-Term Care UB-04 Billing Instructions for Durable Medical Equipment (DME) submitted by Nursing Facilities (NF's) NFs and Intermediate Care Facilities (ICFs)

Implemented changes will result in the payment for DME items presently paid to DME providers being paid to the nursing facility or ICF provider.

These instructions are not intended for DME Claims for residents in hospital swing-beds, hospice care in a NF or ICF, and residents of an assisted living facility.

Rental claims must include a 'from and thru date span', not to exceed one calendar month.
NFs & ICFs and Providers [j1] must use the specific codes for repair & labor as related to the equipment.
NFs & ICFs and Providers [j2] must use K0108 for miscellaneous wheelchair parts. If E1399 is used it will be denied.
NFs & ICFs and Providers [j3] must use correct procedure code modifier's per the DME Fee Schedule.

Purchased items are considered property of the client and will be transferred with them upon discharge or upon death will be turned over to family or legal/personal representative.

UB-04 FORM COMPLETION AND SUBMISSION

DME Policy:
http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-07.pdf

DME Fee Schedule:
http://dhhs.ne.gov/medicaid/Documents/471-000-507-12.pdf

Electronic Billing:
http://dhhs.ne.gov/medicaid/Pages/med_edindex.aspx

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, http://dhhs.ne.gov/Documents/471-000-99.pdf, for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Remittance Advice Remark Codes: http://www.wpc-edi.com/reference/

Claims Status: http://dhhs.ne.gov/medicaid/Pages/med_claimstatus.aspx

Internet Access for Providers: http://dhhs.ne.gov/medicaid/Pages/med_internetaccess.aspx

Claim Form UB-04 Completion Instructions: The numbers listed below correspond to the numbers of the fields on the form. Completion of fields identified as required are mandatory for claim acceptance. Information in fields marked optional or situational is needed for some aspect of claims processing/resolution. Fields identified as N/A are not needed for Nebraska Medicaid claims.

These instructions can be used in combination with the CMS-1450 (UB-04) claim form instructions in the National Uniform Billing Committee Data Specifications Manual's CMS-1450 (UB-04) claim form instructions. This Data Specifications Manual is available from the National Uniform Billing Committee at: http://www.nubc.org

FIELD LOCATION ELEMENT DESCRIPTION	REQUIREMENT
1. **Provider Name, Address & Telephone Number**	**Required**
2. **Pay-To Name and Address:** Facility Name and Address Only.	**Required**
3a. **Patient Control Number:** Will be included on the Remittance Advice.	**Optional**
3b. **Patient's Medical Record Number:** Provider's assigned number to patient record.	**Optional**
4. **Type of Bill:** Use Bill Type Code 23x Only.	**Required**
5. **Federal Tax Number**	**Required**
6. **Statement Covers Period:** From and Thru Dates for Rental month, Date of Service for Purchase.	**Required**
7. **Unlabeled**	**Not Used**
8a. **Medicaid ID #, Complete 11 Digit #**	**Required**
8b. **Patient's Name:** Person who received equipment, Last/First/M.I..	**Required**
9. **Patient's Address**	**Required**

FIELD LOCATION	ELEMENT DESCRIPTION	REQUIREMENT
10.	**Patient's Birthdate, MM/DD/Year**	**Required**
11.	**Patient's Sex**	**Required**
12.	**Admission Date**	**Required**
13.	**Admission Hour**	**Not Used**
14.	**Type of Admission/Visit** Only Use Code" 3-Elective.".	**Required**
15.	**Source of Admission**	**Not Used**
16.	**Discharge Hour**	**Not Used**
17.	**Patient Discharge Status** Refer to UB Manual for Coding.	**Required**
18-28.	**Condition Codes**	**Not Used**
29.	**Accident State**	**Not Used**
30.	**Unlabeled**	**Not Used**
31-34.	**Occurrence Codes and Dates**	**Situational**
35-36.	**Occurrence Span Codes and Dates**	**Not Used**
37.	**Unlabeled**	**Not Used**
38.	**Responsible Party Name and Address**	**Not Used**
39-41.	**Value Codes and Amounts**	**Situational**
42.	**Revenue Code:** Use Revenue Type 29x Only.	**Required**
43.	**Revenue Code and Description:** Refer to #42 and UB Manual for Description.	**Required**
44.	**HCPCS Code/Modifier (If required):** Refer to DME Fee Schedule.	**Required**
45.	**Date of Service:** List date dispensed or, if rental list start date.	**Required**

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FIELD LOCATION ELEMENT DESCRIPTION	REQUIREMENT
46. **Units of Service**	**Required**
47. **Total Charges**	**Required**
48. **Non-Covered Charges**	**Not Used**
49. **Reserved for Future Use**	**Not Used**
50. **Payer Identification (Name):** Use when another payer was primary to Medicaid	**Situational**
51. **Health Plan Identification Number:** Use when another payer was primary to Medicaid	**Situational**
52. **Release of Information Certification**	**Not Used**
53. **Assignment of Benefit Certification**	**Not Used**
54. **Prior Payments:** *For services listed on this claim, enter any payments made, due, or obligated from other sources unless the source is Medicare. Other sources may include health insurance, liability insurance, excess income, etc. **A copy of the Medicare Explanation of Benefits (EOB), insurance remittance advice, and explanation of benefits, denial, or other documentation must be attached to each claim when submitting multiple claim forms.	**Situational**
55. **Estimated Amount Due**	**Not Used**
56. **NPI:** The unique 10 digit identification number assigned to the provider submitting the claim. Enter the National Provider Identifier (NPI) of the Billing Provider, as reported to Nebraska Medicaid.	**Required**
57. **Other Provider ID's**	**Not Used**
58. **Insured's Name**	**Not Used**
59. **Patient's Relation to Insured:** Use Patient Relationship code 18 for all claims.	**Required**

FIELD LOCATION ELEMENT DESCRIPTION   **REQUIREMENT**

60.   **Insured's Unique ID:**   **Required**
Enter the Medicaid recipient's complete eleven-digit
identification number.

61.   **Insured's Group Name:**   **Situational**
Recommended when Nebraska Medicaid is the secondary payer.

62.   **Insured's Group Number:**   **Situational**
Recommended when Nebraska Medicaid is the secondary payer.

63.   **Treatment Authorization Codes**   **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**   **Not Used**

66.   **Diagnosis/Procedure Code Qualifier**   **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/Other 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 or that develop subsequently, and that affect the
treatment received and/or the length of stay.

68.   **Unlabeled**   **Not Used**

FIELD LOCATION ELEMENT DESCRIPTION   **REQUIREMENT**

69.	**Admitting Diagnosis Code**	**Not Used**
70.	**Patient's Reason for Visit Code**	**Not Used**
71.	**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**
73.	**Unlabeled**	**Not Used**
74.	**Principal Procedure Code/Date**	**Not Used**
75.	**Unlabeled**	**Not Used**
76.	**Attending Name/ID-Qualifier:** Enter the attending practitioner's last and first name. <u>NOTE: Enter the National Provider Identifier (NPI) of the ordering physician.</u>	**Required**
77.	**Operating ID**	**Not Used**
78-79.	**Other ID**	**Not Used**
80.	**Remarks**	**Situational**
81.	**Taxonomy**	**Required**
81cc.a	**Taxonomy Code of the Billing Provider:** Enter the 10-digit taxonomy code of the Billing Provider, as reported to Nebraska Medicaid.	**Required**
81cc.b	**Zip Code of the Billing Provider:** Enter the nine-digit Zip Code (Zip+4) of the Billing Provider, as reported to Nebraska Medicaid.	**Required**