Provider Claims & Billing Guide

Molina Healthcare of Nebraska, Inc.
Heritage Health
EFFECTIVE DATE: 01/05/2024

Disclaimer

This Provider Billing Guide, provided by Molina Healthcare, is intended to assist providers in understanding general billing practices for a range of claims. It does not encompass all billing requirements for all covered benefits. These guidelines are for reference purposes only, and providers are encouraged to consult state and federal policies for specific claim submission requirements. If there is a conflict between the Molina Provider Manual or this Provider Billing Guide, the Molina Provider Manual shall govern. If there is a conflict between your Agreement, the Molina Provider Manual, this Provider Billing Guide and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes, and regulations and/or state contracts will control. Molina reserves the right to supplement this Provider Billing Guide to ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations. While we aim to address common billing questions, please note that exact billing instructions may vary, and this Provider Billing Guide cannot be used to substitute what is required by applicable federal and state statutes and regulations and/or state contracts.

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Claims Submission Information

Claim Submission

Participating providers are required to submit claims to Molina with appropriate documentation. Molina will accept 275 unsolicited transactions — additional information to support a health care claim or Encounter — through our clearinghouse. Providers must follow the appropriate state and Centers for Medicare and Medicaid (CMS) provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or the Availity Essentials portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional claims, 837P for professional claims and 837D for dental claims). For members assigned to a delegated medical group/Independent Physician Association (IPA) that processes its own claims, please verify the claim submission instructions on the member's Molina ID card.

Providers must bill Molina for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge.

Required Elements

Electronic submitters should use the Implementation and Molina Companion Guides for formatting and code set information when submitting or receiving files directly with Molina. In addition to the Implementation and Companion Guides, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as added information is available. Please check the Molina website under EDI Companion Guides for regularly updated information regarding Molina's Companion Guide requirements. Be sure to choose the appropriate state from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the state health plan specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic claim submissions will adhere to specifications for submitting medical claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for Compliance SNIP 7.

The following information must be included on every claim, whether electronic or paper:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges
- Place and type of service code
- Days or units as applicable
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Specialty Type/Taxonomy (as applicable)
- Rendering provider information when different than billing

- Billing/pay-to provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), HCPCS/CPT Code and the unit of measure and quantity for all drug claims
- E-signature
- Service facility location information
- Any other state-required data

Provider and member data will be verified for accuracy and active status. Be sure to validate this data in advance of claims submission. Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim.

When claims are filed electronically providers should receive two types of responses:

- Molina will provide a 999 acknowledgement of the transmission.
- Molina will provide a 277CA response file for each transaction.

Submitting a Prior Authorization (PA) Request

Molina will only process completed PA request forms. The following information MUST be included for the request form to be considered complete:

- Member's first name, last name, date of birth and identification number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity, and directions of use
- Diagnosis

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing, Molina will either fax or call your office to request clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

The preferred method for submitting prior authorizations is through the Availity Essentials Portal: https://availity.com/molinahealthcare.

In the event you are unable to use the Availity Essentials Portal, you may call Molina's Healthcare Services department at (844) 782-2678 Monday – Friday, 7am-6pm CST or fax a completed PA request form to Molina at (308) 318-5000.

Claims Payment Information

Payment Frequency

Molina will perform claim payments once a week for the month of January 2024. Subsequently, beginning in the following months, claim payments will take place three times per week.

Claim Payment

If you are signed up for EFT, you should expect to see account deposits five business days from the date of your claim payment Please note, if a provider has never received a payment through ECHO from Molina, their default payment will be a virtual card. You may opt out of virtual cards and choose checks at any time by following the instructions on the card.

If you are on checks/virtual card payments, they will be mailed two business days after the claim payment date.

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 90% within 15 days of the receipt
- 99% within 60 days of the receipt

Claims Interest: Molina will pay providers interest at an annualized rate of 12%, for the full period in which a payable clean claim remains un-adjudicated beyond the 60-day claims processing deadline. Interest owed to the provider must be paid the same day that the claim is adjudicated.

Contacts for Molina:

Plan Address/Administrative Office:

Molina Healthcare of Nebraska
14748 W Center Rd, Suite 104
Omaha, NE 68144
(Please do not submit any claims, reconsiderations or appeals to this address.)

Claims/Reconsiderations/Appeals Address:

Molina Healthcare of Nebraska, Inc.
Attn: Appeals & Grievances Unit
PO Box 182273
Chattanooga, TN 37422
Email: MolinaHC.NE.AnG@molinahealthcare.com

Cost Recovery Disputes and Correspondences:
Molina Healthcare of Nebraska, Inc.
PO Box 2470
Spokane, WA 99210-2470

Claims Refund Address:
Molina Healthcare of Nebraska, Inc

PO Box 604234
Charlotte, NC 28260-4234

Provider Customer Service:

(844) 782-2678, (TTY: 711), Monday – Friday, 7am - 6pm CT

Electronic Visit Verification (EVV)

Nebraska Medicaid will begin implementation of the new Electronic Visit Verification (EVV) for services in a member's home on **January 1, 2024**

The 21st Century Cures Act (2016) requires Nebraska Medicaid to implement a new electronic visit verification (EVV) system for Medicaid personal assistance services and home health providers. EVV electronically records and verifies provider visit information.

EVV uses technology to collect the six data points identified in the 21st Century Cures Act:

1. Service Type
2. Individual Receiving the Service
3. Date of Service
4. Location of Service Delivery
5. Individual Providing the Service
6. Begin and End Time of Service

Molina contracts with Netsmart for EVV.

Technical Support Center: (833) 483-5587 available 24 hours a day
https://www.ntst.com/support/client-support

Electronic Claims Submission

Network providers are encouraged to participate in Molina's electronic claims/encounter filing program: Molina Healthcare 12N 837 professional, institution or encounter transactions. In addition, it can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). Providers that bill electronically have the same timely filing requirements as providers filing paper claims. In addition, providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Molina Healthcare's Payor ID for Physical and Behavioral Health is MLNNE. Our Clearinghouse vendor is SSI. For questions or more information on electronic filing, please contact: SSI: (800) 356-0092

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Molina provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access

of remittance information and straightforward reconciliation of payments. As a provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses – ERA's can be imported directly into practice management or patient accounting systems, eliminating the need for manual re- keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep total control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advice quickly – You can associate electronic payments with ERA's quickly and easily
- Receive payment and remittance advice quicker by registering with Change Healthcare. Change Healthcare is a free multi-payor solution. To sign up, call (888) 834-3511 or email ECHO at EDI@echohealthinc.com.

EFT/ERA Information

For more information on our EFT and ERA services, please contact:
Molina Healthcare
Provider Services Department
(844) 782-2678 Monday – Friday, 7 a.m. – 6p.m. CST, (TTY:711)

Change Healthcare
(888) 834-3511
EDI@echohealthinc.com

Common Causes of Claims Processing Delays & Denials

- Incorrect form type
- Diagnosis code missing digits
- Missing or invalid procedure or modifier codes
- Missing or invalid DRG code
- Explanation of benefits from the primary carrier is missing or incomplete
- Invalid member ID
- Invalid place of service code
- Provider TIN and NPI do not match
- Invalid revenue code
- Dates of service span do not match listed days/units
- Missing physician signature
- Invalid TIN
- Missing or incomplete third-party liability Information

Molina will send providers written notification via the EOP for each claim that is denied, which will include the reason(s) for the denial.

Causes of Up-Front Rejections

- Unreadable Information
- Missing billing provider taxonomy code
- Missing member date of birth

- Missing member name or identification number
- Missing provider name, tax ID or NPI number
- Date of service on the claim is not prior to receipt date of the claim
- Dates are missing from required fields
- Invalid or Missing Type of Bill
- Missing, invalid or incomplete diagnosis code
- Missing service line detail
- Member not effective on the date of service
- Invalid original claim ID for corrected claims
- Admission type is missing
- Missing patient status
- Missing or invalid occurrence code or date
- Missing or invalid revenue code
- Missing or invalid CPT/procedure code
- Incorrect form type
- Claims submitted with handwritten data or black and white forms

Molina will send providers a letter or report for each claim that is rejected explaining the cause for the rejection.

Clinical Laboratory Improvement Amendment (CLIA) Accreditation

All laboratory testing performed on humans in the U.S. is regulated by CMS through the Clinical Laboratory Improvement Amendments (CLIA). Laboratory services for Molina must be provided through a CLIA certified lab in accordance with CLIA law. The CLIA ID should be indicated in field 23 on CMS-1500.

Any claim that does not contain the CLIA ID, has an invalid ID, has a lab accreditation level that does not support the billed service code and/or does not have complete servicing provider demographic information will be considered incomplete and rejected. Types of CLIA Certificates:

- Certificate of waiver
- Certificate of registration
- Certificate of accreditation
- Certificate for physician-performed microscopy
- Certificate of compliance

All lab claims must include the CLIA certification number except for single line claims with one of the following procedures:

36415	36416	36600

Timely Filing

Providers must submit all claims, corrected claims and encounters within 180 calendar days of the date of service. The filing limit may be extended where the eligibility has been retroactively received by Molina, up to a maximum of 180 calendar days.

If Molina is not the primary payer under coordination of benefits or third-party liability, the provider must

submit claims to Molina within 180 calendar days after final determination by the primary payer.

Claim disputes and appeals must be received within 90 calendar days from the date of notification of payment or denial is issued.

Third-Party Liability / Coordination of Benefits

Third-party liability refers to any other health insurance plan, carrier (e.g., individual, group, employer-related, self-insured, self-funded, commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the member. Any other insurance, including Medicare, is always primary to Medicaid coverage. Molina/Medicaid is always the payer of last resort. Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina has other insurance that is primary. Providers must submit claims to the primary insurance for consideration and submit a copy of the Explanation of Benefits (EOB), Explanation of Payment (EOP) or rejection letter from the other insurance when the claim is filed. If this information is not sent with an initial claim filed for a member with insurance primarily to Medicaid, the claim will be denied until this information is received. If a member has more than one primary insurance (Medicaid would be the third payer), the claim cannot be submitted through EDI or the secure web portal and must be submitted on a paper claim.

Crossover / Coordination of Benefits Agreement (COBA)

Molina's policies and processes align with the CMS-developed national contract, the COBA, which standardizes how eligibility and Medicare claims payment information within an exchanged claim's crossover. Our affiliates have also passed multiple, rigorous readiness reviews with state regulators and CMS, demonstrating the ability to properly administer authorizations and adjudicate pharmacy and acute claims, and apply appropriate cost sharing with holding members harmless.

Under COBA, Medicaid providers submit claims for dually eligible members to the Medicare FFS claims system for processing. Medicare will:

1. Process the claims
2. Apply any deductible/coinsurance or copay amount
3. Forward the claim to Molina for further claims processing

Overpayments related to TPL/COBA

Overpayments related to TPL/COBA will contain primary insurer information necessary for rebilling including the policy number, effective date, term date and subscriber information. For members with commercial COBA, Molina will provide notice within 270 days from the claim's paid date if the primary insurer is a commercial plan. A provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A provider shall pay a claim for an overpayment made by Molina which the provider does not contest or dispute within the specified number of days on the refund request letter mailed to the provider. If a provider does not repay or dispute the overpaid amount within the time allowed Molina may offset the overpayment amount(s) against future payments made to the provider.

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the provider receives a payment from Molina that reduces or deducts the overpayment.

"Lessor of" Logic

Secondary payment will be determined by paying the lessor of:

1. The difference between the amounts paid as if the Medicaid plan was primary and the actual payment was made from the primary plan; or
2. The amount reflected as the member's responsibility by the primary payer.

    - Example 1 – Code 15845 – Billed $800. Negotiated Rate is $600. MCO pays $600 negotiated rate.
    - Example 2 – Code 15845 – Billed $300. Negotiated Rate is $500. MCO pays $300 billed rate.

Provider Claim Dispute Process

All claim requests for reconsideration must be received within 90 calendar days from the date of the EOP. If a provider has a question or is not satisfied with the information have received related to a claim, they may reach out to Molina in the following ways:

- Contact a Molina Provider Service representative, Monday-Friday: (844) 782-2678 (TTY:711), 7am-6pm CST.
- Providers may discuss questions regarding the amount reimbursed or denial of a particular service.
- Contact the assigned provider relations representative assigned to your facility/organization.
- Submit an adjusted or corrected claim via the provider portal or in writing to:

    Molina Healthcare
    Attn: Claims
    PO Box 182273
    Chattanooga, TN 37422

- The claim must include the original claim number in field 22 of a CMS-1500 or field 64 of the UB-04. Failure to include the original claim number and frequency code may result in the claim being denied as a duplicate, a delay in the reprocessing or denial for exceeding the timely filing limit.
- Submit a claim reconsideration request in writing with supporting documentation via mail to:

    Molina Healthcare
    Attn: Claim Reconsiderations
    PO Box 182273
    Chattanooga, TN 37422

Molina shall process and finalize all adjusted claims, requests for reconsideration and disputed claims within 30 calendar days of receipt of the corrected claim, request for reconsideration or claim dispute. Below are the different reconsideration situations:

- First time disputing a payment/denial of a claim
- Provider has disputed payment/denial of the claim once before but has now made changes to their billing
- Dispute changes due to a change in denial/status of the claim

Claim Appeal

In order to file a claim appeal or dispute, the provider MUST have received an adverse benefit determination. When filing a claim appeal within 90 days of the adjudication date, appeals should include a letter detailing the reason for the appeal, as well as, all supporting documents, such as, but not limited to – medical records.

Mail your claim appeal form and all other attachments to:

Molina Healthcare of Nebraska, Inc.
Appeals & Grievances Unit
PO Box 182273
Chattanooga, TN 37422
Email: MolinaHC.NE.AnG@molinahealthcare.com

Molina will process and finalize claim appeals within 30 calendar days of receipt of the claim appeal.

If a provider's submission of a corrected claim, request for reconsideration or claim appeal results in an adjusted claim, the provider will receive a revised EOP. If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for the next level appeal.

Provider Refunds

When a provider sends a refund for claims processed, the refund must be sent to the following address:
Molina Healthcare of Nebraska, Inc
PO Box 604234
Charlotte, NC 28260-4234

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

- **Procedure code invalid rules:** Evaluates claims for invalid procedure and revenue or diagnosis codes
- **Deleted codes:** Evaluates claims for procedure codes which have been deleted
- **Modifier to procedure code validation:** Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, -26, -57, -58 and -59.
- **Age rules:** Identifies procedures inconsistent with member's age
- **Gender procedure:** Identifies procedures inconsistent with member's gender
- **Gender diagnosis:** Identifies diagnosis codes inconsistent with member's gender
- **Incomplete/invalid diagnosis codes:** Identifies diagnosis codes incomplete or invalid

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of Molina's clinical validation services is modifiers -25 and -59 review.

When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion, or separate injury (modifier -59). Molina Healthcare's clinical validation team uses the information on the prospective claim and claims history to determine whether it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

CMS supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

Modifier 59

The NCCI (National Correct Coding Initiative) states the primary purpose of modifier -59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate under the circumstances. The CPT Manual defines modifier -59 as follows: "Modifier - 59: Distinct Procedural Service. Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier -59 is used to identify procedures/services, other than E/M services, which are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Molina Healthcare uses the following guidelines to determine if modifier -59 was used correctly.

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated.
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas, which would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier -59 were used appropriately.

Modifier 25

Both CPT and CMS specify in the NCCI policy manual that by using a modifier -25 the provider is indicating that a "significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service." Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra-, and post-operative care associated with the procedure that was performed.

The NCCI policy manual states that "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E/M service. However, a significant and separately

identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. The E/M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare carriers and A/B MACs processing practitioner service claims have separate edits.

Molina Healthcare uses the following guidelines to determine whether or not modifier -25 was used appropriately.

If any one of the following conditions is met, the clinical nurse reviewer will recommend reimbursement for the E/M service.

- If the E/M service is the first time the provider has seen the patient or evaluated a major condition.
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed.
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services.
- Other procedures or services performed for a member on or around the same date of the procedure support that an E/M service would have been required to determine the member's need for additional services.

Emergency Room Services

Emergency services means covered inpatient and outpatient services that are as follows:

- Furnished by a provider that is qualified to provide these services under Title XIX of the Social Security Act.
- Needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, if a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- Serious impairment to bodily organ or part. See 42 CFR §438.114(a).

Urgent care means those services rendered for an urgent medical condition or the protection of public health. An urgent medical condition means a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, would expect the illness or injury to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in jeopardy.
- Impairment to bodily functions.
- Dysfunction of any bodily organ or part.

Emergent and urgent care services are covered by Molina without authorization. Screening and examination services conducted to determine if an emergency medical condition exists are also covered by Molina. This includes non-contracted providers inside or outside of Molina's service area. Emergency services are available 24 hours per day, 7 days per week. Molina will process and adjudicate claims for non-contracted providers at the same amount that would have been paid if the service had been provided under Nebraska for service Medicaid program.

Consideration for Emergency Medical Services

Molina wants to ensure that each member has access to timely and appropriate care for emergency-related conditions. To this end, Molina will not:

- Limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms.
- Refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the member's primary care provider, the MCO or applicable state entity of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.
- Members will not be held liable for payment of subsequent screening and treatment need to diagnose the specific condition or stabilize the member.

The attending emergency physician or the provider treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

Before providing non-emergency services and imposing cost-sharing for such services on a member, the hospital must:

- Inform the member of the amount of their cost-sharing obligation for non-emergency services provided in the emergency department.
- Provide the member with the name and location of an available and accessible alternative non-emergency services provider. If geographical or other circumstances prevent the hospital from meeting this requirement, cost-sharing may not be imposed.
- Determine that the alternative provider can provide services to the member in a timely manner with the imposition of a lesser cost-sharing amount. The assessment of access to timely services shall be based on the medical needs of the enrolled member.
- Provide a referral to coordinate scheduling for treatment by the alternative provider.

Hospital Readmissions

The Medicaid National Correct Coding Initiative (NCCI) program was made to help states reduce improper payments in Medicaid and Children's Health Insurance Programs (CHIP).

The Medicaid NCCI contains two types of edits:

1. Procedure-to-Procedure (PTP) edits define pairs of Healthcare Common Procedure Coding System (HCPCS) /Current Procedural Terminology (CPT) codes that should not be reported together for various reasons. The PTP edits prevent improper payments when incorrect code combinations are reported.
2. Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code, the maximum Units of Service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

Please visit the CMS National Correct Coding Initiative (NCCI) website for more information https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci.

Other Relevant Information

Session Limits

Any covered benefits with session limits will be based on a calendar year cycle. Using a calendar year as the basis for session limits can simplify tracking and managing benefits, especially when it comes to benefits that renew or reset on an annual basis.

The count for these benefits resets at the beginning of each calendar year (January 1st). So, if a person has a benefit with a session limit of 20 visits per year and they've used all 20 visits by December 31st, they will have a fresh allocation of 20 visits starting on January 1st of the following year.

Interim Billing

When interim billing, be sure to enter the appropriate Type of Bill code (e.g., 112, 113, 114). A patient status code of 30 (still a patient) must use the appropriate Type of Bill code (e.g., 112, 113).

Balance Billing / Member Acknowledgment Statement

Providers may not balance bill Molina members for any reason for covered services. Detailed information regarding the billing requirements for non-covered services is available in the Provider Manual. Providers must inform the member of their responsibility for payment of non-covered services prior to services being rendered.

The provider must obtain a written acknowledgment from the member to bill the member for non-covered services. Please have the member sign the following Member Acknowledgment Statement:

I understand that the services or items that I have requested to be provided to me on [dates of service] may not be covered by Molina Healthcare of Nebraska, and in the opinion of [Provider's Name] they are reasonable and medically necessary for my care. I understand that Molina, through its contract with Nebraska Medicaid, determines medical necessity for the services and items I receive. The cost of services to be rendered are estimated

to be [price]. I understand that I am responsible for the payment of non-covered services and items that I request and receive if those services are not medically necessary or reasonable.

Newborn Billing

Providers should submit newborn claims with the newborn's Medicaid ID number. Claims with date of service after the date of birth will use the child's full birth name as the subscriber's name.

599CHIP/Unborn Billing

Members under the 599CHIP/Unborn program have access to a limited set of covered services. These services include prenatal care and pregnancy-related services solely for the health of the unborn child. It does not cover postpartum care and medical issues separate to the pregnant woman's health and unrelated to the pregnancy. On the claim form, list the patient's name as the mother's name in box 2. Include the member ID of the unborn child that is found on the member ID card in box 1A. In box 4 enter "unborn" as insured's first name and mother's last name as insured's last name.

Atypical Providers

Atypical providers are service providers that do not meet the definition of health care provider. Examples include taxi services, home and vehicle modifications, insect control, habilitation, and respite services, etc. Although they are not required to register for an NPI, these providers perform services that are reimbursed by Molina. Atypical providers must use the state assigned atypical NPI number given to them by the state of Nebraska to replace the NPI. Providers should report the full atypical provider identification number and the outlining requirement for the G2 qualifier.

Behavioral Health and Substance Abuse Services

Behavioral health and substance abuse services may be billed by community mental health centers and other behavioral health service providers. More information can be found on the web site at: https://dhhs.ne.gov/Pages/Behavioral-Health.aspx

State Resources

For additional information regarding Nebraska Medicaid resources and requirements, please see the resources below.

Resources	Link
Fee Schedules	https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx
Provider Bulletin/Signup for Provider Bulletin	https://dhhs.ne.gov/Pages/Medicaid-Provider-Bulletins.aspx
Home and Community Based Services (HCBS) Provider Manual	https://dhhs.ne.gov/Pages/Medicaid-Home-and-Community-Based-Programs.aspx
Medicaid Provider Manuals	https://dhhs.ne.gov/Pages/Medicaid-Providers.aspx

General Resources

Resources	Link
March Vision	https://www.marchvisioncare.com/becomeprovider.aspx
MTM	https://www.mtm-inc.net/#NEMT
SkyGen, USA	https://app.dentalhub.com/app/login
Netsmart Login	https://www.ntst.com/solutions/by-capability/electronic-visit-verification
Sign up for EFT/ERA	https://enrollments.echohealthinc.com/EFTERAInvitation
CMS National Correct Coding Initiative (NCCI)	https://www.cms.gov/national-correct-coding-initiative-ncci
Centers For Medicare & Medicaid Services	https://www.cms.gov/

Appendix I

Durable Medical Equipment Billing

Rental Items

- Codes paid at a monthly rental rate should be billed as one unit per line with a date span of one month.
- Codes paid at a daily rental rate should be billed with from/to dates of service that reflect the beginning and end of the rental period. The number of units billed should reflect the total number of days within that rental period.
    - Daily rental date spans should not include more than 31 days (about 1 month).
    - If a member's month-to-month eligibility changes in the middle of a date span for daily rental, the claim line should then be split consistent with eligibility dates.

Purchase Items

Except for codes for diabetic supplies, infusion pumps and enteral/parenteral nutrition supplies, purchased items should not be billed with a date span.

- When date span billing purchase items, bill the total number of units supplied, and span the number of days that the supply is for.

Federally Qualified Health Center (FQHC)/Rural Health Center (RHC)

FQHC and RHC providers are reimbursed at the Benefits Improvement and Protection Act of 2000 (BIPA) rate or the interim rate if a BIPA rate has not been determined Note: Bill with correct place of service (50 – FQHC; 72– RHC), and bill with appropriate encounter codes T1015 and CPT Codes (T1015 must be billed on the first claim line for all encounters). When billing for an encounter, bill with the group NPI in box 33b. When billing fee for service, bill rendering provider NPI in box 24j and group NPI in box 33b.

Hospice

Medicaid provides a daily reimbursement for every day that a member is hospice eligible. The daily rate is one of the four categories of care:

- Routine home hospice care (Revenue Code 651): The hospice will be paid the routine home care (RHC) rate for each day the member is at home, under the care of the hospice and not receiving continuous home care.
- Continuous home hospice care (Revenue Code 652): Continuous home care is covered when it is provided to maintain a member at home during a period of medical crisis. A crisis is when a member requires continuous care, primarily nursing care to achieve palliation or management of acute medical symptoms.
- Inpatient respite care (Revenue Code 655): Respite inpatient care is short-term inpatient care provided to the member only when necessary to relieve the family members or other persons caring for the member at home. Respite care is not paid when the hospice member is residing in a nursing facility.
- General inpatient care (Revenue Code 656): General inpatient care is provided in periods of acute medical crisis when the member is hospitalized for pain control or acute or chronic symptom management.
- The hospice claim will deny if:
    - Value Code 61 is not present
    - Member CBSA/Special Wage Index Code number of the Medicaid client's home is not submitted with Value Code 61

More information regarding hospice claims for service intensity add-on services can be found in the following Provider Bulletin: https://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2019-15.pdf.

Observation Room

When billing for a facility, code G0378 should be used to bill for outpatient services. Please see the Nebraska Medicaid EAPG Pricing Training located here: https://dhhs.ne.gov/Documents/EAPG%20Training.pdf

In addition, at least 8 units of G0378 (observation services, per hour) *up to* 48 hours must be reported. After 48 hours, the patient must either be admitted as an inpatient by written order or discharged.

Out-of-Network Providers

With the exception of single case agreements and other arrangements established with out-of-network providers, Molina will pay out-of-network providers no less than 90% of the rate of reimbursement to in-network providers unless otherwise required by law or regulatory requirement. Molina will pay noncontracted providers for emergency services the amount that would have been paid if the service had been provided under the state's fee-for-service Medicaid program.

Present on Admission (POA) Indicator

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been prevented using evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

The following is a list of CMS HACs. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not POA:

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
    a. Fractures
    b. Dislocations
    c. Intracranial Injuries
    d. Crushing Injuries
    e. Burn
    f. Other injuries
6. Manifestations of Poor Glycemic Control
    a. Hypoglycemic Coma
    b. Diabetic Ketoacidosis
    c. Non-Kenotic Hyperosmolar Coma
    d. Secondary Diabetes with Ketoacidosis
    e. Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)

8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures:
    a. Spine
    b. Neck
    c. Shoulder
    d. Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a. Laparoscopic Gastric Restrictive Surgery
    b. Laparoscopic Gastric Bypass
    c. Gastroenterostomy
12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Latrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a. Total Knee Replacement
    b. Hip Replacement

- Acute IPPS hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: https://www.cms.gov/.

Present on Admission (POA) Indicator Codes:

- **Y:** The condition was present or developing at the time of the order for inpatient admission.
- **N:** The condition was not present or developing at the time of the order for inpatient admission.
- **U:** Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
- **W:** Clinically undetermined. The provider cannot clinically determine if the condition was present or developing at the time of the inpatient admission order.

Leave the POA indicator field blank if the ICD-10 diagnosis is excluded from reporting the POA indicator.

Swing Bed Nursing Facility

Swing-bed placement is only intended to be short-term. Swing-bed stays beyond 14 days (about 2 weeks) will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission.

- For these criteria, an "appropriate" nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member's medical condition and corresponding LOC needs.
- A Medicaid member who has been in a swing bed beyond 14 days (about 2 weeks) must be discharged

to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours (about 3 days) of an appropriate nursing facility bed becoming available.

Appendix II: Physician Administered Drug Billing Information

1. MDRP Requirement:

    a. Only to be covered if drug qualifies for rebate from the Medicaid Drug Rebate Program (MDRP) (Medicaid.gov).

    b. Nebraska Medicaid will determine the rebate eligibility of drugs using the labeler code that identifies the manufacturer; the labeler code is the first 5 digits of the (11-digit) NDC code.

2. 340B

    a. All 340B CEs (providers) that use 340B drugs and serve Medicaid (FFS and MCO) members must do one of the following:

        i. 340B Medicaid CARVE-OUT

            1. Medicaid CARVE-OUT all prescriptions, physician-administered drugs, and other products from the 340B program.

            2. Use non-340B drugs for all Medicaid (FFS or managed care) members you serve.

            3. Bill only for drugs, vaccines and diabetic supplies purchased outside the 340B program billed in accordance with existing Medicaid (FFS or managed care) reimbursement methodologies, allowing rebates to be collected where appropriate.

            4. Do not list the 340B entity's NPI on the HRSA Medicaid Exclusion File. This allows rebates to be collected where appropriate.

        ii. 340B Medicaid CARVE-IN

            1. Use 340B drugs for all Medicaid (FFS or MC) members you serve.

            2. Inform OPA at the time of 340B enrollment that you intend to purchase and dispense 340B drugs for Medicaid (FFS or MC) members.

            3. Do not bill Medicaid (FFS or MC) for 340B acquired drugs and products if your NPI is not listed on the HRSA Medicaid Exclusion File.

            4. Purchase all drugs and other products billed to Medicaid (FFS or MC) on the CE's NPI under 340B unless the product is not eligible for 340B pricing.

            5. This ensures these claims are excluded from the Medicaid rebate.

            6. Carved in entities should append the appropriate modifier to indicate that the drug was obtained through the 340B program at a discounted price (UD, TB, and JG).

    b. Non-340B Claims: If the product is not eligible for 340B pricing do not include a modifier and bill at the regular Medicaid rate.

3. Injections
    a. Are not covered when they are not specific for an effective treatment for the condition for which they are administered. We will look at the fee schedule for covered and non-covered codes.
    b. The following information must be provided when billing for injections:
        i. HCPCS code
        ii. NDC
            1. Must consist of 11 digits in a 5-4-2 format
        iii. Units of service
            1. Unit qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are:

F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit

        iv. Charge for each injection*
            1. *When billing an "unlisted" J code (otherwise known as a "dump" code), in addition to the three bulleted items directly above, the provider should also indicate the charge for the injection.
    c. Allergenic Extract
        i. Injections used for self-administration are allowed. We will look at the fee schedule for covered and non-covered codes.
4. Vaccines
    a. Vaccine administration services covered by Nebraska Medicaid and designated in the health care common procedure coding system (HCPCS) as codes 90472, 90473, and 90474, or their successor codes.
    b. COVID 19 Administration fees may need to change (see COVID 19 Administration fees)
    c. Not covered immunizations for travel
        i. 90476, 90665, 90717, 90477, 90690, 90725, 90581, 90691, 90727, 90585, 90692, 90735, 90693, 90738
    d. Vaccine for Children (VFC) Program
        i. Payment for vaccines available through the VFC Program will be approved only if the VFC program stock has been depleted.
        ii. In order to be paid for the administration of a vaccine covered under the VFC Program, a physician must enroll in the VFC program. Provider must bill with an SL modifier to indicate the administration of the VFC.

e. Bill the appropriate vaccine administration codes for the vaccine administration in addition to the CPT code for the vaccine. Basis of reimbursement is physician fee schedule, health check fee schedule and enhanced payments to primary care providers fee schedule.

f. All vaccines are excluded from rebate program.

5. Electronic Loops and Segments for Reporting

837I / 837P		
Data Element	Loop	Segment/Element
NDC	2410	LIN03
Unit of Measure	2410	CTP05-01
Unit Price	2410	CTP03

Appendix III: Common EDI Rejection Codes and Descriptions

These are common rejection codes and their descriptions for EDI submissions from SSI. All errors indicated must be corrected before the claim is resubmitted:

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
01a. MISSING OR INVALID INSURED ID	195016	131850	Policy number (2010BA/2330 B*NM109) cannot be blank, must be at least 2 characters in length and must be a valid string.	A6	153	IL
02. MISSING OR INVALID PATIENT FIRST NAME	195018	77532	Patient first name (2010CA*NM1 04) cannot be blank and must be a valid string.	A6	125	QC
02. MISSING OR INVALID PATIENT LAST NAME	195022	10680	Patient last name (2010CA*NM 103) Must begin with an alpha character.	A6	125	QC
03 MISSING OR INVALID PATIENT SEX CODE	195023	57540	Patient gender (2010BA/201 0CA*DMG03) must be M, F or U.	A7	157	QC
03. PATIENT BIRTHDATE REQUIRED	195024	55106	Patient birth date (2010BA*DM G02) must be a valid date and cannot be later than the submission date.	A6	158	QC
04. INSURED FIRST NAME INVALID	195026	70681	Primary insured's first name (2010BA*NM 104) cannot	A6	125	IL

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
			be blank if insured's entity (2010BA*NM 102) is "1" (person).			
04. INSURED FIRST NAME INVALID	195244	70681	If insureds entity (2010BA*NM 102) is '2' (non-person) then the insured's first name (2010BA*NM 104), middle initial/middle name(2010CA*NM105) and generation (2010BA*NM 07) must be blank.	A6	125	IL
04. INSURED FIRST NAME INVALID	195245	70681	Secondary insured's first name (2010BA*NM 104) cannot be blank if insured's entity (2010BA*NM 102) is "1" (person).	A6	125	IL
04. INSURED FIRST NAME INVALID	195246	70681	If insured’s entity (2010BA*NM 102) is '2' (non-person) then the insured's first name (2010BA*NM 104), middle initial/middle name(2010CA*NM105) and generation (2010BA*NM	A6	125	IL

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
			07) must be blank.			
04. INSURED LAST NAME INVALID	195029	74080	Insured's last name (2010ba*nm 103) cannot be blank. Colons are not allowed.	A6	125	IL
05. PATIENT'S ADDRESS INVALID	195031	75150	Patient street address (2010BA*N301) can only contain valid characters A-Z 0-9! & ' , + ( ) - . / ; ? = Note: colon *asterisk ^ carat and ~ tilde are not valid.	A6	126	QC
05. PATIENT CITY INVALID	195053	75161	Patient city (2010ba*n40 1) must be at least two characters and must be valid string.	A6	502	QC
05. PATIENT STATE INVALID	195077	75196	Patient state (2010BA*N4 02) must be at least two characters in length.	A7	501	QC
05. Patient zip invalid for state	195078	75168	Patient zip code (2010BA*N4 03) must be at least 9 characters.	A7	500	QC
05. Patient zip invalid	195197	72517	Patient zip code (2010BA/201 0CA*N403) must be 5 or 9 numeric and must be a valid US zip code.	A7	500	QC
06. Patient relation invalid	195079	130058	Relationship to insured	A7	156	

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
			(2000C/2320 *SBR02) must be:01 = SPOUSE, 18 = SELF, 19 = CHILD, 20 = EMPLOYEE, 21 = UNKNOWN, 39 = ORGAN DONOR, 40 = CADAVER DONOR, 53 = LIFE PARTNER, G8 = OTHER RELATIONS			
Insured zip code not valid for insured state or is not 5 or 9 numeric characters.	195198	72525	Primary Insureds zip code (2010BA*N4 03) must be 5 or 9 numeric and must be a valid zip code.	A7	500	IL
<Various messages depending on particular missing data>			No Edit	A7	448	
09. Other insured date of birth same as patient, but another insured name does not match patient			No Edit	A7	125	GB
09. Other ins. first name invalid	199264		Another subscriber first name (2010CA*NM 104) cannot be blank if other payer name (2330B*NM1 03) is	A6	125	GB

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
			submitted.			
09. Other ins. first name invalid	199265		Another subscriber first name (2010CA*NM 104) cannot be blank if other payer name (2330B*NM1 03) is submitted.	A6	125	GB
09. Another ins. birthdate invalid			No Edit	A6	158	GB
09. Other ins. sex invalid			No Edit	A7	157	GB
11. Primary payor ID invalid	195344	34590	Primary payor name (2010BB*NM 103/2330B* NM103) cannot be blank and must be a valid string.	A7	26	PR
15. Date of similar illness invalid	195345		Similar symptom date (2300*DTP*4 38) must be after submission date.	A7	192	
20. Lab charges invalid			No Edit	A6	179	
21.1 Diagnosis code invalid			No Edit	A7	255	
21.2 Diagnosis code invalid			No Edit	A7	255	
21.3 Diagnosis code invalid			No Edit	A7	255	
21.4 Diagnosis code invalid			No Edit	A7	255	
24a. From date of service must be present and cannot be prior to onset or accident date	195080	3876	Service from date (2400*DTP*4 72) cannot be blank.	A7	448	
P.O.S. invalid	195081	131822	Place of Service	A7	249	

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
			(2400*Sv105) must be valid.			
Modifier 1 must be 2 characters	195082	5733	Modifier (2400*SV101-3) must be two alphanumeric.	A7	453	
Modifier 2 must be 2 characters	195083	5735	Modifier (2400*SV101-4) must be two alphanumeric.	A7	453	
Modifier 3 must be 2 characters	195084	49186	Modifier (2400*SV101-5) must be two alphanumeric.	A7	453	
24d. Procedure code invalid	195085	25320	Procedure code (2400*SV101-2) must be a valid CPT or HCPCS code.	A7	454	
24e Invalid diagnosis pointer 1	195187	71133	Diagnosis pointer 1 (2400*Sv107-1) must be 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 or 12.	A7	477	
24e Invalid diagnosis pointer 2	195188	132694	Diagnosis pointer 2 (2400*Sv107-2) must be 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 or 12.	A7	477	
24e Invalid diagnosis pointer 3	195189	132696	Diagnosis pointer 3 (2400*Sv107-3) must be 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 or 12.	A7	477	
24e Invalid diagnosis pointer 4	195190	132697	Diagnosis pointer 4 (2400*Sv107	A7	477	

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
			-4) must be 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 or 12.			
24e. Missing diagnosis pointer is blank	195086	67887	Diagnosis pointer (2400*SV107 -1) cannot be blank.	A7	477	
8 possible messages: (1) No adjustment segments present for prior adjudication. One or more CAS segments are required in LOOP 2430 when SVD segment is present	195106	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	Primary adjustment group code (2320/2430* CAS01) is required and must be CO, CR, OA, or PR.	A7	448	
8 possible messages: (2) Missing or invalid claim paid date for prior adjudication. DTP segment required in LOOP 2430 when SVD segment is present. Date reported cannot be greater than current date.	195107	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	Adjudication date (2330B*DTP* 573) is required.	A7	448	
8 possible messages: (3) Service adjustments and payments do not balance. Sum of adjustments and payments must equal service charge	195108	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	Claim level adjustments (2320*CAS) are required when COB total paid amount (2320*AMT* D) does not equal the total charges	A7	448	

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
			(CLM02).			
8 possible messages: (4) Claim adjustments and payments do not balance. Sum of adjustments and payments must equal claim charge	195108	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	Claim level adjustments (2320*CAS) are required when COB total paid amount (2320*AMT*D) does not equal the total charges (CLM02).	A7	448	
8 possible messages: (5) Missing claim paid amount. The segment is required in loop 2320 when the claim has been adjudicated by the payer.	195109	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	COB total payer paid (2320*AMT*D) is required and must be greater than 0 (zero) if claim level adjustments (2320*CAS) do not equal the total charges (2300*CLM02).	A7	448	
8 possible messages: (6) COB Payer ID Missing or Invalid. Payer ID is required in NM109 in loop 2330B. If segment SVD is present in loop 2430, SVD02 must also be present and match the loop 2330B value		(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	No Edit	A7	448	
8 possible messages: (7) Adjustment data missing	195106	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606	Primary adjustment group code (2320/2430*CAS01) is	A7	448	

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
or payer id mismatch. CAS segments are required for each payer where prior adjudication is indicated, and the total payments for that payer do not equal the claim charges. Payer IDs in LOOP 2430 must match those in LOOP 2330B		(6) No Edit (7) 182107 (8)No Edit	required and must be CO, CR, OA, or PR.			
8 possible messages: (8) Service level adjudication present using a payer ID that matches the ID for multiple payers in loop 2330B. NM109 in loop 2330B must be unique across all iterations of that loop for a claim if those values are used in SVD01 in loop 2430.		(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	No Edit	A7	448	
Patient account number is required	195111	11489	Patient account number (2300*CLM*01) cannot be blank and cannot be longer than	A6	478	

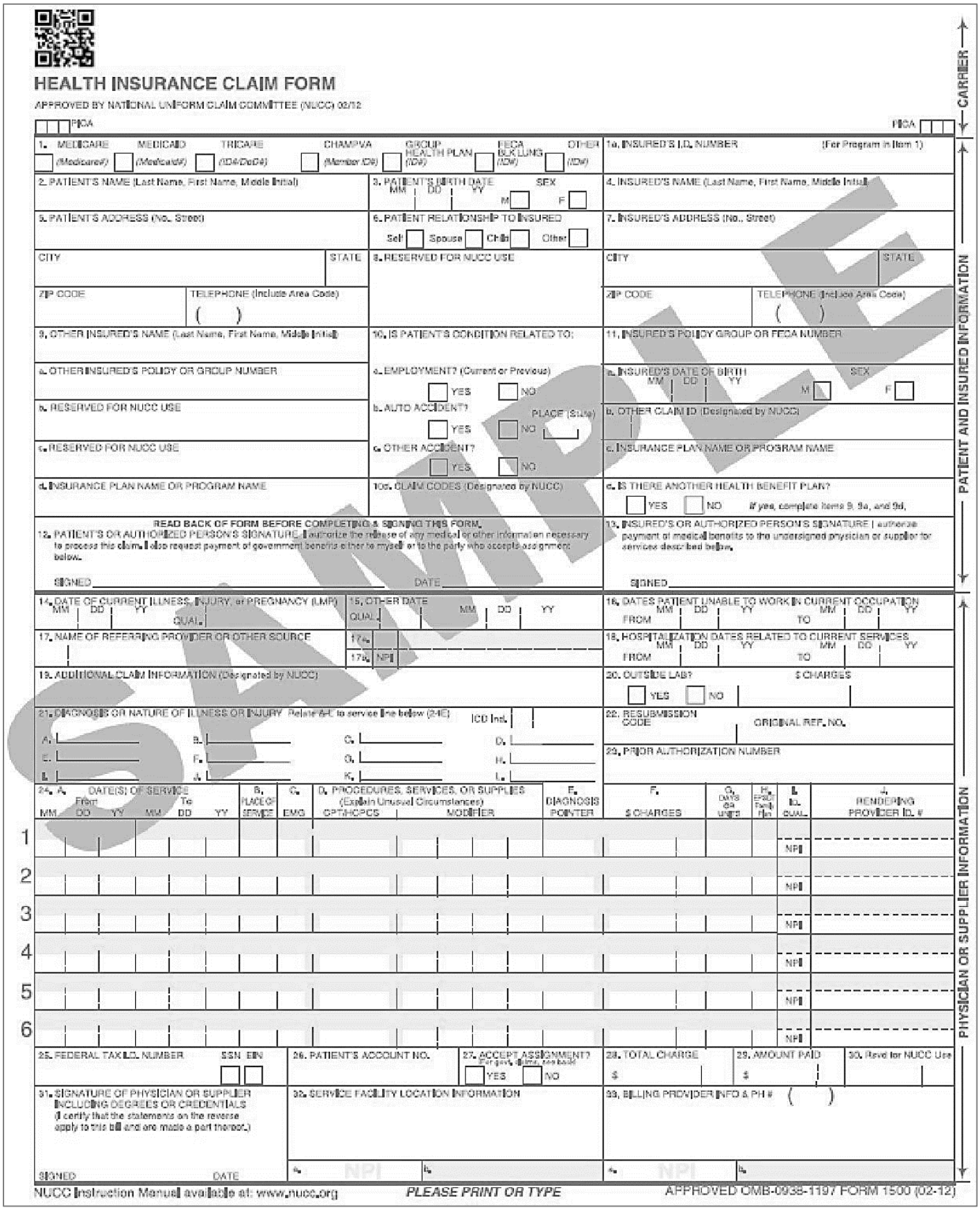
Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
			20 characters and must be a valid string.			
31. Missing physician name in the provider table When submitting claims as an individual, the physician's name must be completed in the provider table of the setup tab.	195112	139608	When billing for a group the rendering physician (2310B*NM1) is required.	A6	125	82
31. Physician name invalid		No Edit	No Edit	A6	125	82
24g. Anesthesia minutes invalid	195113	90056	Charge Measuremen t Code (2400*SV103) must be MJ for anesthesia related charges.	A6	251	
Invalid ordering provider primary id qualifier. It must be 24, 34, or XX.	195114	106561 133874	Ordering Provider NPI (2420*NM10 9) is required.	A7	745	DK
Invalid ordering provider primary id qualifier. It must be 24, 34, or XX.	195115	106561 133874	If Physician Identifier code 82, QB, DQ, DK, DN, or P3(2430*NM 102) exist then the associated NPI (2420*NM10 9) is required.	A7	745	DK

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
Invalid Provider City must be at least two characters. Please update in the Provider table of the Setup Tab.	195116	76452	Provider city (2010AA*N401) must be at least two characters.	A7	502	85
Invalid Provider State. Please update in the Provider table of the Setup Tab.	195117	131676	Provider state (2010AA*N402) is required.	A7	501	85
Provider address must be physical address	195118	131669	Provider address line 1 (2010AA*N301) must be the physical address.	A7	126	85
Rendering provider primary id qualifier must be XX and primary id must be valid NPI	195119	131799	If Physician Identifier code 82, DQ, DN, or P3 (2310*NM102) exist then the associated NPI (2310*NM109) is required.	A7	562	82
2 possible messages: (1) Drug quantity is missing. CPT04 is required in loop 2410 when NDC code is submitted	195120	133626 133627	-National Drug Unit Count (2410*CTP04) is required. -National Drug Unit Count (2410*CTP04) must be blank if NDC (2410*LIN03) is blank.	A6	216	
2 possible messages: (2) Drug unit code	195186	133626 133627	Drug code qualifier (2410*ctp05)	A6	216	

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
is missing or invalid. CPT05-1 is required in loop 2410 when NDC code is submitted			must be F2, GR, ME, ML, UN.			
Claim total charges (CLM02) must equal sum of service line charges (SV102)			No Edit	A7	448	
Billing provider NPI is required	195121	130043	Billing provider NPI (2010AA*NM 109) cannot be blank.	A7	562	85
Procedure code qualifier invalid. ICD-10 qualifiers required.			No Edit	A7	448	
Claim cannot contain a mix of ICD-9 and ICD-10 procedure code qualifiers.	195122	25270	Diagnosis code must be a valid ICD9 (2300*HI*BK /BF) or ICD10(2300* HI*ABK/ABF) code.	A7	448	
Diagnosis code invalid.	195122	25270	Diagnosis code must be a valid ICD9 (2300*HI*BK /BF) or ICD10(2300* HI*ABK/ABF) code.	A7	255	
3 possible messages: (1) Servic e dates cannot span ICD-10 code implemen tation date	195122	25270	Diagnosis code must be a valid ICD9 (2300*HI*BK /BF) or ICD10(2300* HI*ABK/ABF) code.	A7	448	

Current Error Message(s)	New Edit number	HAG	New edit description	Claim Status Category	Claim Status	Entity
(2) Services prior to ICD-10 implementation date must use ICD-9 diagnosis codes. Services after ICD-10 implementation date must use ICD-10 diagnosis codes.						
21. Diagnosis code out of sequence. Codes must be present in order without skipping.			No Edit	A7	448	
Primary diagnosis cannot be external cause of injury code	195191	160171	ICD-10-CM Diagnosis codes (2300*HI*ABK/ABF) in the range V00-Y999 cannot be used as primary diagnosis code.	A7	448	
Release of benefits indicator is invalid			No Edit	A7	333	
Release of information code is invalid			No Edit	A7	360	
Claim does not balance. Sum of service charges does equal total charges			No Edit	A7	400	

Appendix IV: Claims Form Instructions CMS 1500



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CMS-1500 (2/12) Claim Form Field Descriptions

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation, or the service provided.

NOTE: Claims with missing or invalid required (R) field information will be rejected or denied.

Field #	Field Description	Instructions or Comments	Required or Conditional
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being filed. Enter "X" in the box noted "Other."	R
1a	INSURED'S I.D. NUMBER	The 9-digit identification number on the member's Nebraska I.D. card	R
2	PATIENTS NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Nebraska I.D. card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE/SEX	Enter the patient's 8-digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. M= Male F= Female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's Nebraska I.D. card	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Does not exist in the electronic 837P.	C
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C
Field #	**Field Description**	**Instructions or Comments**	**Required or Conditional**
7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state.	C

Field #	Field Description	Instructions or Comments	Required or Conditional
		Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Does not exist in the electronic 837P.	
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. Required if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	Required if field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	Required if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a,b,c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED POLICY OR FECA NUMBER	Required when other insurance is available. Enter the policy, group or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier have been designated for use: Y4 Property Casualty Claim Number **FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH	Mark Yes or No. If Yes, complete field's 9a-d	R

Field #	Field Description	Instructions or Comments	Required or Conditional
	BENEFIT PLAN	and 11c.	
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C
15	OTHER DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported. 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation (This is for property and causality only)	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials). *This field is required for PT/OT/ST/DME/Hearing Aid service claims	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C

Field #	Field Description	Instructions or Comments	Required or Conditional
		*This field is required for PT/OT/ST/DME/Hearing Aid service claims	
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Note:** Claims missing or with invalid diagnosis codes will be rejected or denied for payment. Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM	R
22	RESUBMISSION CODE / ORIGINAL REF. NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services.	If auth = C If CLIA = R (If both, always submit the CLIA number)
24a-j	GENERAL INFORMATION	Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line, there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields.	
20	OUTSIDE LAB / CHARGES		C
24a-j (continued)	GENERAL INFORMATION (continued)	The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier and Provider number.	

Field #	Field Description	Instructions or Comments	Required or Conditional
		Shaded boxes 24 a-g is for line-item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line-item detail.	
24 A-G Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract Rate For detailed instructions and qualifiers refer to Appendix III of this guide.	C
24 A Unshaded	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was performed (MM|DD|YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line.	R
24 B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R
24 C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24 D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R
24 E Unshaded	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should be listed first; other applicable services should follow. The	R

Field #	Field Description	Instructions or Comments	Required or Conditional
		reference letter(s) should be A–L or multiple letters as applicable. ICD-9-CM or ICD-10-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service, or the claim will be rejected/denied. This field allows for the entry of 4 characters in the unshaded area.	
24 F Unshaded	CHARGES	Enter the charge amount for the claim line-item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar R sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24 G Unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.	C
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy. Use G2 qualifier for ID if an Atypical Provider.	R
24 J Shaded	NON-NPI PROVIDER ID#	Typical Providers: Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. Atypical Providers: Enter the Provider ID number.	R
24 J Unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number, and mark the box labeled EIN	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	C
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a	C

Field #	Field Description	Instructions or Comments	Required or Conditional
		Nebraska recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS-1500 (02-12) Claim Form for the section pertaining to Payments.	
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line. REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Nebraska. Nebraska programs are always the payers of last resort.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Nebraska. Nebraska programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
		Note: Does not exist in the electronic 837P.	
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (PO Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: Required if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	OTHER PROVIDER ID	Required if the location where services were rendered is different from the billing address listed in field 33. Typical Providers: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers: Enter the 2-character qualifier ID (no spaces).	C
33	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code) and phone number. First line -Enter the business/facility/practice name. Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line -In the designated block, enter the city and state. Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555)555-5555). NOTE: The 9-digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
33a	GROUP BILLING NPI	Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHERS ID	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.	R

Appendix V – Claims Form Instructions – UB-04

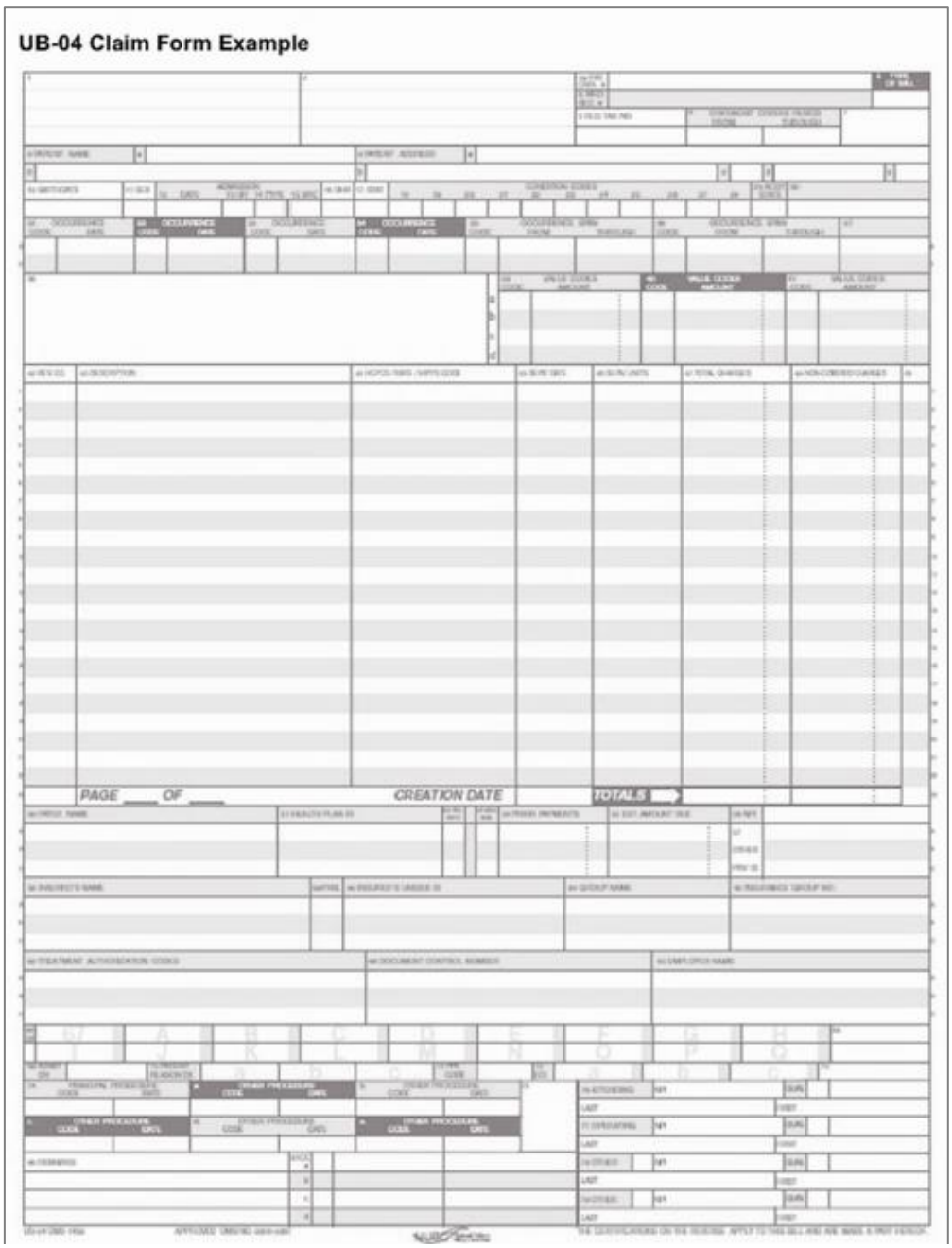
Completing a UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital claim charges for reimbursement by Nebraska. In addition, a UB-04 is required for home health agencies, nursing home admissions, inpatient hospice services and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for correction.

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims: Professional fees must be billed on a CMS-1500 claim form. Include the appropriate CPT code next to each revenue code. Please refer to your provider contract with Nebraska or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.

UB-04 Claim Form Example



UB-04 Claim Form Field Descriptions

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation, or the service provided.

Field #	Field Description	Instructions or Comments	Required or Conditional
1	Unlabeled Field	LINE 1: Enter the complete provider's name. LINE 2: Enter the complete mailing address. LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). NOTE: The 9-digit zip (zip +4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	Unlabeled Field	Enter the Pay- to Name and Address.	Not Required
3a	Patient Control No.	Enter the facility patient account/control number.	Not Required
3b	Medical Record Number	Enter the facility patient medical or health record number.	R
4	Type Of Bill	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading “0” (zero). A leading “0” is not needed. Digits should be reflected as follows: 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code).	R
5	Fed. Tax No	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	Statement Covers Period From/ Through	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	Unlabeled Field	Not Used.	Not Required
8a	Patient Name	8a – Enter the first 9 digits of the identification number on the member’s Nebraska I.D. card	Not Required
8b	Patient Name	8b – Enter the patient’s last name, first name, and middle initial as it appears on the Nebraska ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g. McKendrick. H). Hyphenated names: Both names should be	R

Field #	Field Description	Instructions or Comments	Required or Conditional
		capitalized and separated by a hyphen (no space). Suffix: a space should separate a last name and suffix. Enter the patient's complete mailing address of the patient.	
9	Patient Address	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: Country Code (NOT REQUIRED)	R (Except line 9e)
10	Birthdate	Enter the patient's date of birth (MMDDYYYY).	R
11	Sex	Enter the patient's sex. Only M or F is accepted.	R
12	Admission Date	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R
13	Admission Hour	Enter the time using 2-digit military times (00-23). 00- 12:00 midnight to 12:59 01- 01:00 to 01:59 02- 02:00 to 02:59 03- 03:00 to 03:39 04- 04:00 to 04:59 05- 05:00 to 05:59 06- 06:00 to 06:59 07- 07:00 to 07:59 08- 08:00 to 08:59 09- 09:00 to 09:59 10- 10:00 to 10:59 11- 11:00 to 11:59 12- 12:00 noon to 12:59 13- 01:00 to 01:59 14- 02:00 to 02:59 15- 03:00 to 03:59 16- 04:00 to 04:59 17- 05:00 to 05:59 18- 06:00 to 06:59 19- 07:00 to 07:59 20- 08:00 to 08:59 21- 09:00 to 09:59 22- 10:00 to 10:59 23- 11:00 to 11:59	R
14	Admission Type	Require for inpatient and outpatient admissions. Enter the 1- digit code indicating the type of the admission using the appropriate following codes: 1. Emergency 2. Urgent 3. Elective 4. Newborn	R

Field #	Field Description	Instructions or Comments	Required or Conditional
		1. Trauma	
15	Admission Source	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For Type of admission 1,2,3, or 5: Physician Referral 1. Clinic Referral 2. Health Maintenance Referral (HMO) 3. Transfer from a hospital 4. Transfer from Skilled Nursing Facility 5. Transfer from another health care facility 6. Emergency Room 7. Court/Law Enforcement 8. Information not available For Type of admission 4 (newborn): 1. Normal Delivery 2. Premature Delivery 3. Sick Baby 4. Extramural Birth 5. Information not available	
16	DISCHARGE HOUR	Enter the time using 2-digit military times (00-23) for the time of the inpatient or outpatient discharge. 00-12:00 midnight to 12:59 01-01:00 to 01:59 02-02:00 to 02:59 03-03:00 to 03:39 04-04:00 to 04:59 05-05:00 to 05:59 06-06:00 to 06:59 07-07:00 to 07:59 08-08:00 to 08:59 09-09:00 to 09:59 10-10- 10:00 to 10:59 11- 11:00 to 11:59 12- 12:00 noon to 12:59 13- 01:00 to 01:59 14- 02:00 to 02:59 15- 03:00 to 03:59 16- 04:00 to 04:59 17- 05:00 to 05:59 18- 06:00 to 06:59 19- 07:00 to 07:59 20- 08:00 to 08:59 21- 09:00 to 09:59 22- 10:00 to 10:59 23- 11:00 to 11:59	C

Field #	Field Description	Instructions or Comments	Required or Conditional
17	PATIENT STATUS	REQUIRED for inpatient and outpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 05 Discharged to another type of institution 06 Discharged to care of home health service Organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutives days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)	R
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character	C

Field #	Field Description	Instructions or Comments	Required or Conditional
		code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	
29	ACCIDENT STATE		Not Required
30	UNLABELED FIELD	Not Used.	Not Required
31-34 a-b	OCCURRENCE CODE and OCCURRENCE DATE	Occurrence Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: **REQUIRED** when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: **REQUIRED** when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
37	UNLABELED FIELD	**REQUIRED** for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES and AMOUNTS	Code: **REQUIRED** when applicable. Value codes are used to identify events relating to the bill	C

Field #	Field Description	Instructions or Comments	Required or Conditional
		that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” field must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: **REQUIRED** when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	
42-47 General Information Fields	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for detailed information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	Rev CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	PAGE OF	Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of pages in the “OF” field. If only one claim form is submitted, enter a “1” in both fields (i.e. PAGE “1” OF “1”). (Limited to 4 pages per claim)	C
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows	C

Field #	Field Description	Instructions or Comments	Required or Conditional
		up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims.	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least “1” must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	UNLABELED FIELD	Not Used.	Not Required
50 A-C	PAYER	Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary.	R
51 A-C	HEALTH PLAN IDENTIFICATION NUMBER		Not Required
52 A-C	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter ‘Y’ (yes) or ‘N’ (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain ‘Y.’	R
53	ASG. BEN.	Enter ‘Y’ (yes) or ‘N’ (no) to indicate a signed form is on file authorizing payment by the payer	R

Field #	Field Description	Instructions or Comments	Required or Conditional
		directly to the provider for services.	
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Nebraska is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10- character NPI ID.	R
57	OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non -NPI number) of the billing provider.	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Nebraska Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4). Frequency of "7" (Replacement of Prior Claim) or Type of Bill. Frequency of "8" (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Not Required

Field #	Field Description	Instructions or Comments	Required or Conditional
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-10-CM Volume 1 & 3 for the date of service.	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-10-CM Volume 1 & 3 for the date of service. Diagnosis codes submitted must be valid ICD-10-CM Codes for the date of service and carried out to its highest level of specificity – 4th or “5” digit. "E" and most “V” codes are **NOT** acceptable as a primary diagnosis. **Note:** Claims with incomplete or invalid diagnosis codes will be denied.	C
68	PRESENT ON ADMISSION INDICATOR	Report the applicable POA indicator (Y, N, U, or W) for the principal diagnosis and any secondary diagnoses as the eighth digit.	R
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-10-CM Volume 1& 3 for the date of service. Diagnosis Codes submitted must be valid 10 Codes for the date of service and carried out to its highest level of specificity – 4th or “5” digit. "E" codes and most “V” is **NOT** acceptable as a primary diagnosis. **Note:** Claims with missing or invalid diagnosis codes will be denied.	R
70	PATIENT REASON CODE	Enter the ICD-10-CM Code that reflects the patient’s reason for visit at the time of outpatient registration. Field 70a requires entry; field’s 70b- 70c are conditional. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or “5” digit. "E" codes and most “V” is **NOT** acceptable as a primary diagnosis. **Note:** Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS/DRG CODE		Not Required
72 a,b,c	EXTERNAL CAUSE CODE	This field is required to be completed when there is a primary trauma diagnosis on the claim.	C

Field #	Field Description	Instructions or Comments	Required or Conditional
73	UNLABELED		Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9/ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-9/ICD-10 Procedure Codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	UNLABELED		Not Required
76	ATTENDING PHYSICIAN	Enter the NPI and name of the physician in charge of the R patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	R
77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	C
78 & 79	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care. (Blank Field): Enter one of the following Provider	C

Field #	Field Description	Instructions or Comments	Required or Conditional
		Type Qualifiers: DN – Referring Provider. ZZ – Other Operating MD. 82 – Rendering Provider. NPI: Enter the other physician 10-character NPI ID. QUAL: Enter one of the following qualifier and ID number: 0B - State license number 1G - Provider UPIN number G2 - Provider commercial number	
80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	Attending Physician	Enter name or 7-digit Provider number of ordering physician.	R

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.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