

2024 Provider Billing Guide



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Introductory Billing Information

Billing Instructions

Nebraska Total Care follows the Centers for Medicare and Medicaid Services (CMS) rules and regulations for billing and reimbursement.

The billing, claims and payment information identified in this guide are applicable to both Nebraska Medicaid and Long-Term Care populations: Heritage Health (HH) and Heritage Health Adult (HHA) Expansion population.

General Billing Guidelines

Physicians, other licensed health professionals, facilities, and ancillary provider's contract directly with Nebraska Total Care for payment of covered services.

It is important that providers ensure Nebraska Total Care has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Medicaid Number
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

Providers must bill with their NPI number in box 24J. We encourage our providers to bill their taxonomy code in box 24Ja to avoid possible delays in processing. Claims missing the required data will be rejected, and a notice sent to the provider, creating payment delays.

We recommend that providers notify Nebraska Total Care 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form to NetworkManagement@NebraskaTotalCare.com. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member must be effective on the date of service (see information below on identifying the member)
- The service provided must be a covered benefit under the member's contract on the date of service
- Referral and prior authorization processes must be followed, if applicable, using the NebraskaTotalCare.com prior authorization "Pre-Auth" check tool online.

Payment for service is contingent upon compliance with payment policies and procedures, as well as the billing guidelines outlined in this manual. When submitting your claim, you need to identify the member. There are two ways to identify the member:

- The member number found on the member ID card or the provider portal.
- The Medicaid Number provided by the State and found on the member ID card or the provider portal.

Claim Forms

Nebraska Total Care only accepts the CMS-1500 (2/12) and CMS-1450 (UB-04) paper claim forms. Other claim form types will be rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS-1500 (2/12) form and institutional providers complete the CMS-1450 (UB-04) claim form. Nebraska Total Care does not supply claim forms to providers. All paper claim forms are required to be typed or printed and in the original red and white version to ensure clean acceptance and processing. All claims with handwritten information or on black and white forms will be rejected, with the exception of Box 31 on HCFA 1500, Nebraska Total Care will allow a Provider Signature, but it must be within box 31, if outside box claim will reject. If you have questions regarding what type of form to complete, contact Nebraska Total Care at 877-600-5472.

Billing Codes

Nebraska Total Care requires claims to be submitted using codes from the current version of, ICD-10, ASA, DRG, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of service
- Code is inappropriate for the age or sex of the member
- Diagnosis code is missing digits
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service

Medical Documentation, itemized statements, and invoices may be required for non-specific types of claims or at the request of Nebraska Total Care. Invoices will be required on unlisted or miscellaneous codes.

CPT® Category II Codes

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

Use of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

Clean Claim Definition

A clean claim means a claim received by Nebraska Total Care for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Nebraska Total Care.

Rejection Versus Denial

All claims must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected.

REJECTION: A list of common upfront rejections can be found listed below (See section titled Common Causes of Upfront Rejections). Rejections will not enter our claims adjudication system, so there will be no explanation of payment (EOP). A rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. For paper claim submissions that reject the provider will receive a letter identifying the rejection reason and for electronic claims submissions a rejection report is generated with the rejection reason codes.

DENIAL: If all minimum edits pass the claim is accepted and it will then be entered into the system for processing. A DENIAL is defined as a claim that has passed minimum edits and is entered into the system, however has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason. A comprehensive list of common delays and denials can be found below (See section titled Common Causes of Claims Processing Delays and Denials).

Claim Payment

Claims Check Run for Nebraska Total Care Claims:

- Finalized claims for Nebraska Total Care providers will be paid every Tuesday and Friday on the weekly check runs. Clean claims will be adjudicated (finalized as paid or denied) at the following levels:
- 90% within 10 business days of the receipt
- 99% within 60 business days of the receipt

Claims Interest: Nebraska Total Care 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 Nebraska Total Care:

Plan Address/Administrative Office:

Nebraska Total Care
2525 N. 117th Ave, Suite 100
Omaha, NE 68164
(Please do not submit any claims/reconsiderations/appeals to this address)

Claims Submission/Reconsiderations/Appeals Address:

Nebraska Total Care
Attn: Claims
PO Box 5060
Farmington, MO 63640-5060

Claims Refund Address:

Nebraska Total Care
Attn: Refunds
PO Box 3713
Carol Stream, IL 60132-3713

Customer Service (Provider and Member Services):

Toll Free: 1-844-385-2192
Nebraska Relay Service 711

Claims Payment Information

Claims for Long-Term Care Facilities

Long-Term Care facilities are required to bill on a UB-04 claim form for all inpatient (inpatient bill type) and outpatient services (outpatient bill type). Please verify authorization at NebraskaTotalCare.com using the Pre-Auth Check Tools. Room and board for long-term members is managed by the State of Nebraska at the per diem rate at this time. Short-term acute stays are a covered benefit by Nebraska Total Care. Room and board and outpatient services are covered by Nebraska Total Care. Room and board will pay off State assigned per diem rate. Outpatient services such as DME, PT/OT/ST will pay off of Nebraska Medicaid Fee Schedules. Prior authorization is required for skilled inpatient services on an IP authorization form. DME and PT/OT/ST require authorization on an OP authorization form. Please verify using the NebraskaTotalCare.com website Pre-Auth Check Tools to see which services require authorization. When submitting claims for short-term sub-acute stays, facilities must ensure they are utilizing the appropriate revenue codes reflecting the short-term stay. We utilize Revenue codes 110179 for Skilled Room and Board.

Electronic Claims Submission

Network providers are encouraged to participate in Nebraska Total Care's electronic claims/encounter filing program. Nebraska Total Care can receive ANSI X12N 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.

Nebraska Total Care's Payor ID for Physical and Behavioral Health is 68069. Our Clearinghouse vendors include Change Healthcare (formerly Emdeon), Envoy, WebMD and Gateway EDI. For questions or more information on electronic filing, please contact:

Nebraska Total Care
C/O Centene EDI Department
1-800-225-2573, ext. 6075525
Fax: 866-266-6985 or E-mail: EDIBA@centene.com

Paper Claim Submission

For Nebraska Total Care members, all claims and encounters should be submitted to:

Nebraska Total Care
Attn: Claims Department
PO Box 5060
Farmington, MO 63640-5060

Requirements

Nebraska Total Care uses an imaging process for paper claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's

- Do use the correct P.O. Box number
- Do submit all claims in a 9" x 12" or larger envelope
- Do type all fields completely and correctly
- Do use typed black or blue ink only at 9-point font or larger
- Do include all other insurance information (policy holder, carrier name, ID number and address) when applicable
- Do include the EOP from the primary insurance carrier when applicable. Note: Nebraska Total Care is able to receive primary insurance carrier EOP [electronically]
- Do submit on a proper original form (CMS-1500 or UB-04)

Don'ts

- Don't submit handwritten claim forms
- Don't use red ink on claim forms
- Don't circle any data on claim forms
- Don't add extraneous information to any claim form field
- Don't use highlighter on any claim form field
- Don't submit photocopied claim forms (no black and white claim forms)
- Don't submit carbon copied claim forms
- Don't submit claim forms via fax
- Don't utilize staples for attachments or multi page documents

Basic Guidelines for Completing CMS-1500 Claim Form (Instructions in Appendix):

- Use one claim form for each recipient.
- Enter one procedure code and date of service per claim line.
- Enter information with a typewriter or a computer using black type.
- Enter information within the allotted spaces.
- Make sure whiteout is not used on the claim form.
- Complete the form using the specific procedure or billing code for the service.
- Use the same claim form for all services provided for the same recipient, same provider and same date of service.
- If dates of service encompass more than one month, a separate billing form must be used for each month.

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

Nebraska Total Care 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 – Electronic remittance advices 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 advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily
- Receive payment and remittance advice quicker by registering with Payspan. Payspan is a free multi-payor solution. To sign up, call 1-877-331-7154 or email Payspan at ProviderSupport@PayspanHealth.com.

EFT/ERA Information

For more information on our EFT and ERA services, please contact:

Nebraska Total Care
 Provider Services Department
 1-844-385-2192, Nebraska Relay Service 711

Payspan
 1-877-331-7154
PayspanHealth.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

Nebraska Total Care 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 Member Date of Birth
- Missing Member Name or Identification Number
- Missing Provider Name, Tax ID, or NPI Number
- The 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
- 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

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

CLIA Accreditation

Labs who participate in the Medicare or Medicaid sector of Nebraska Total Care must be CLIA accredited. Requirements for laboratory accreditation are contained in the [Comprehensive Accreditation Manual](http://jcrinc.com/store/publications/manuals/) for Laboratory and Point-of-Care Testing (CAMLAB) located at jcrinc.com/store/publications/manuals/.

How to Submit a CLIA Claim

Via Paper

Complete Box 23 of a CMS-1500 form with CLIA certification or waiver number for those laboratory services for which CLIA certification or waiver is required.

*Note - An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS-1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Via EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

-Or-

If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4

**Note* - The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4. When the referring laboratory is the billing laboratory, the referring laboratory's name, NPI, address, and Zip Code shall be reported in loop 2310C. The 2420C loop is required if different then information provided in loop 2310C. The 2420C would contain Laboratory name and NPI.

Via Web

Complete Box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

**Note* - An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS-1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the referring laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Claim Reconsideration Requests & Corrected Claims

All claim requests for reconsideration and corrected claims must be received within 90 calendar days from the date of the Explanation of Payment (EOP). If a provider has a question or is not satisfied with the information they have received related to a claim they may reach out to Nebraska Total Care in the following ways:

- Contact a Nebraska Total Care Provider Service Representative at 1-844-385-2192, Nebraska Relay Service 711. Providers may discuss questions with Nebraska Total Care Provider Services Representatives regarding 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 Nebraska Total Care, Attn: Claims, PO Box 5060, Farmington, MO 63640-5060. 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 using the **Reconsideration Form** with supporting documentation via mail to: Attn: Claim Reconsiderations, PO Box 5060, Farmington, MO 63640-5060

Nebraska Total Care shall process, and finalize all adjusted claims, requests for reconsideration and disputed claims to a paid or denied status 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 the provider MUST have received an unsatisfactory response to a request for claim reconsideration. Submit the following items when filing a claim appeal within 60 days of the adjudication date:

- **Claim Appeal Form**
- Original Request for Reconsideration letter and response
- Any supporting documentation supporting the appeal

Mail your Claim Appeal Form and all other attachments to:

Nebraska Total Care
Attn: Claim Appeal
PO Box 5060
Farmington, MO 63640-5060

Nebraska Total Care shall 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 Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for next level appeal.

Provider Refunds

When a provider sends a refund for claims processed, the refund must be sent to the following address:

Nebraska Total Care
Attn: Refunds
PO Box 3713
Carol Stream, IL 60132-3713

Third Party Liability / Coordination of Benefits

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member. Any other insurance, including Medicare, is always primary to Medicaid coverage.

Nebraska Total Care 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 Nebraska Total Care members. If a member has other insurance that is primary, you must submit your claim to the primary insurance for consideration, and submit a copy of the Explanation of Benefits (EOB) or 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 primary to Medicaid, the claim will deny 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.

Billing the Member / Member Acknowledgement Statement

Nebraska Total Care reimburses only services that are medically necessary and covered through the program. Providers are not allowed to "balance bill" for covered services if the provider's usually and customary charge for covered services is greater than our fee schedule.

Providers may bill members for services NOT covered by either Medicaid or Nebraska Total Care or for applicable copayments, deductibles or coinsurance as defined by the State of Nebraska.

In order for a provider to bill a member for services not covered under the program, or if the service limitations have been exceeded, the provider must obtain a written acknowledgment following this language (the Member Acknowledgement Statement):

I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Integrated Care Program as being reasonable and medically necessary for my care. I understand that Nebraska Total Care through its contract with the Nebraska Department of Healthcare and Family Services determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

Nebraska Total Care Code Auditing & Editing

Nebraska Total Care uses HIPAA compliant clinical claims auditing software for physician and outpatient facility coding verification. The software will detect and document coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of correct coding utilizing industry standards and government sources. These principles are aligned with a correct coding “rule.” When the software audits a claim that does not adhere to a coding rule, a recommendation known as an “edit” is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code auditing software is a useful tool to ensure provider compliance with correct coding, a fully automated code auditing software application will not wholly evaluate all clinical patient scenarios.

Consequently, the health plan uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios that justify payment above and beyond the basic service performed.

Moreover, Nebraska Total Care may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

CPT codes are a component of the HealthCare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. Current Procedural Terminology (CPT) codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised and deleted) on an annual basis.

Level I HCPCS Codes (CPT): This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a 5- digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.

Level II HCPCS: The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics, prosthetics, etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated on an annual basis.

Miscellaneous/Unlisted Codes: The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office

notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

- **Temporary National Codes:** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.
- **HCPCS Code Modifiers:** Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD 10)

These codes represent classifications of diseases. They are used by healthcare providers to classify diseases and other health problems. On UB 1450 claim form, providers must fill out 74 A-E for Inpatient only. Outpatient services require Revenue codes and HCPCS/CPT code combinations.

Revenue Codes

These codes represent where a patient had services performed in a hospital or the type of services received. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

Code Auditing & Claims Adjudication Cycle

Code auditing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code auditing cycle, each service line on the claim is processed through the code auditing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Code Auditing Principles

The below principles do not represent an all-inclusive list of the available code auditing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

Unbundling

CMS National Correct Coding Initiative-

cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

CMS developed the correct coding initiative to control erroneous coding and help prevent inaccurate claims payment. CMS has designated certain combinations of codes that should never be billed together. These are also known as Column One/Column Two edits. The Column One procedure code is the most comprehensive code and reimbursement for the Column Two code is subsumed into the payment for the comprehensive code. The Column One code is considered an integral component of the Column Two code.

The CMS NCCI edits consist of procedure to procedure (PTP) edits for physicians and hospitals and the Medically Unlikely Edits for professionals and facilities. While these codes should not be billed together, there are circumstances when an NCCI modifier may be appended to the Column II code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed.

PTP Practitioner and Hospital Edits

Some procedures should not be reimbursed when billed together. CMS developed the Procedure to Procedure (PTP) Edits for practitioners and hospitals to detect incorrect claims submitted by medical providers. Practitioner PTP Edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). The Hospital PTP Edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers and comprehensive outpatient rehabilitation facilities.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

MUE's reflect the maximum number of units that a provider would bill for a single member, on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyst, equipment prescribing information and clinical judgment.

Code Bundling Rules Not Sourced to CMS NCCI Edit Table

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling

Two or more procedure codes are used to report a service when a single, more comprehensive should have been used. The less comprehensive code will be denied.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0, 10 or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0 or 10 day global surgical period are designated as minor procedures.

Evaluation and Management services for a major procedure (90-day period) that are reported 1-day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.

Evaluation and Management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

Evaluation and Management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing

Procedures with “MMM - Global periods for maternity services are classified as “MMM” when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (3-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility; they are considered bundled into the inpatient admission, and therefore, are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes if a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all of the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member’s lifetime. State fee schedules also delineate the number of

times a procedure can be billed over a given period of time or during a member's lifetime (Nebraska Example: 60 combined PT/OT/ST therapy units for adults in one year; 12 chiropractic visits in one calendar year).

Duplicate Edits

Code auditing will evaluate prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software will also look across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of service. Finally, the software will analyze multiple services within the same range of services performed on the same day. For example, a nurse practitioner and physician bill for office visits for the same member on the same day.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid Revenue to Procedure Code Editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

Rule evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claims analysis. 80 and AS will be accepted.

Co-Surgeon/Team Surgeon Edits

CMS guidelines define whether or not an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co-surgeon or team surgeon.

Add-on and Base Code Edits

Rules look for claims where the add-on CPT code was billed without the primary service CPT code or if the primary service code was denied, then the add-on code is also denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one, when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

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

Administrative & Consistency Rules

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 Nebraska Total Care's clinical validation services is modifier -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). Nebraska Total Care's clinical validation team uses the information on the prospective claim and claims history to determine whether or not it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

The Centers for Medicare and Medicaid Services (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, that 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.

Nebraska Total Care 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 postoperative 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.

Nebraska Total Care 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.

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

This edit identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of post-admission follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Payment & Coverage Policy Edits

Payment and Coverage policy edits are developed to increase claims processing effectiveness, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers regarding these policies. It encompasses the development of payment policies based on coding and reimbursement rules and clinical policies based on medical necessity criteria, both to be implemented through claims edits or retrospective audits. These policies are posted on each health plan's provider portal when appropriate. These policies are highly customizable and may not be applicable to all health plans.

Claim Reconsiderations Related to Code Auditing and Editing

Claims appeals resulting from claim-editing are handled per the provider claims appeals process outlined in this manual. When submitting claims appeals, please submit medical records, invoices and all related information to assist with the appeals review.

If you disagree with a code audit or edit and request claim reconsideration, you must submit medical documentation (medical record) related to the reconsideration. If medical documentation is not received, the original code audit or edit will be upheld.

Other Important Information

Health Care Acquired Conditions (HCAC) – Inpatient Hospital

Nebraska Total Care follows Medicare's policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for HCACs. Acute care hospitals and Critical Access Hospitals (CAHs) are required to report whether a diagnosis on a Medicaid claim is present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included on Medicare's most recent list of HCACs and for which the condition was not present on admission, the HCAC secondary diagnosis is not used for DRG grouping. That is, the claim is paid as though any secondary diagnoses (HCAC) were not present on the claim. POA is defined as "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses. Providers should refer to the CMS Medicare website for the most up to date POA reporting instructions and list of HCACs ineligible for payment.

Reporting & Non-Payment for Provider Preventable Conditions (PPCs)

Provider Preventable Conditions (PPCs) addresses both hospital and non-hospital conditions identified by Nebraska Total Care for non-payment. PPCs are defined as Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). Medicaid providers are required to report the occurrence of a PPC and are prohibited from payment.

Non-Payment & Reporting Requirements Provider Preventable Conditions (PPCs) - Inpatient

Nebraska Total Care follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NCDs service/procedure (as a PPC) is reported. If covered services/procedures are also provided during the same stay, the health plan follows Medicare's billing guidelines requiring hospitals submit two claims: one claim with covered services, and the other claim with the non-covered services/procedures as a non-pay claim.

Inpatient hospitals must appropriately report one of the designated ICD diagnosis codes for the PPC on the no-pay TOB claim. Nebraska Total Care follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NDC service/procedure (as a PPC) is reported.

Other Provider Preventable Conditions (OPPCs) – Outpatient

Medicaid follows the Medicare guidelines and national coverage determinations (NCDs), including the list of HAC conditions, diagnosis codes and OPPCs. Conditions currently identified by CMS include:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive surgery performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Non-Payment & Reporting Requirements Other Provider Preventable Conditions (OPPCs) – Outpatient

Medicaid follows the Medicare guidelines and national coverage determinations (NCDs), including the list of HAC conditions, diagnosis codes and OPPCs. Outpatient providers must use the appropriate claim format, TOB and follow the applicable NCD/modifier(s) to all lines related to the surgery(s).

Lesser of Language

Unless specifically contracted otherwise, Nebraska Total Care's policy is to pay the lesser of billed charges and negotiated rate.

- Example 1 – Code 12345 – Billed \$600. Negotiated Rate is \$500. Nebraska Total Care pays \$500 negotiated rate.
- Example 2 – Code 12345 – Billed \$500. Negotiated Rate is \$600. Nebraska Total Care pays \$500 billed rate.

Timely Filing

Providers must submit all 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 Nebraska Total Care, up to a maximum of 180 calendar days. When Nebraska Total Care is the secondary payer, claims must be received within 365 calendar days of the date of service.

All claim requests for reconsideration or corrected claims must be received within 90 calendar days from the date of notification of payment or denial. Claims appeals must be received within 60 calendar days from the date of notification of payment or denial is issued.

Use of Assistant Surgeons

An Assistant Surgeon is defined as a physician who utilizes professional skills to assist the Primary Surgeon on a specific procedure. All Assistant Surgeon's procedures are subject to retrospective review for Medical Necessity by Medical Management. All Assistant Surgeon's procedures are subject to health plan policies and are not subject to policies established by contracted hospitals.

Hospital medical staff bylaws that require an Assistant Surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff bylaws alone do not constitute medical necessity. Nor is reimbursement guaranteed when the patient or family requests an Assistant Surgeon be present for the surgery. Coverage and subsequent reimbursement for an Assistant Surgeon's service is based on the medical necessity of the procedure itself and the Assistant Surgeon's presence at the procedure.

Additional Billing Information

Hospice

Hospice services are billed to Nebraska Total Care on Form CMS-1450, Health Insurance Claim Form.

Type of Bill Required

Valid hospice bill types = 81__ and 82-__

For hospice services, Nebraska Total Care allows the following revenue codes:

- 651 - Routine Home Care
- 652 - Continuous Home Care
- 655 - Inpatient Respite Care
- 656 - General Inpatient Care

*Note: No other revenue codes are accepted.

The revenue codes must be billed with the appropriate corresponding HCPC as follows:

- T2042- Routine Home Care
- T2043 - Continuous Home Care
- T2044 - Inpatient Respite Care
- T2045 - General Inpatient Care

*Note: No other procedure codes are accepted. Only one procedure code per day may be billed.

For further clarification review [Nebraska Medicaid regulations in section 471-36-000](#) and [Appendix 471-000-81](#).

Obstetrics Billing

Global OB Care

The total obstetric care package includes the provision of antepartum care, delivery services and postpartum care. When the same group physician and/or other health care professional provides all components of the OB package, report the Global OB package code.

The CPT for Global OB codes are:

- 59400 – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- 59510 – Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- 59610 – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- 59618 – Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Billing Guidelines

The global maternity allowance is a complete, one-time billing, which includes all professional services for routine antepartum care, delivery services and postpartum care. The fee is

reimbursed for all of the member's obstetric care to one provider. If the member is seen four or more times prior to delivery for prenatal care and the provider performs the delivery and performs the postpartum care, then the provider must bill the Global OB code. Global OB care should be billed on or after the delivery date.

Non-global OB care

Non-global OB care, or partial services, refers to maternity care not managed by a single provider or group practice. Billing for non-global re may occur if:

- A patient transfers into or out of a physician or group practice
- A patient is referred to another physician during her pregnancy
- A patient has the delivery performed by another physician or other health care professional not associated with her physician or group practice
- A patient terminates or miscarries her pregnancy
- A patient changes insurers during her pregnancy

Billing Guidelines

Antepartum care only reporting:

- If only one to three antepartum visits were provided, report the appropriate E/M codes, according to CPT® guidelines.
- If four to six visits are provided, report 59425 antepartum care only.
- If seven or more visits are provided, report 59426 antepartum care only.
- Each date of service should be billed with one (1) unit per date.
- The dates reported should be the range of time covered. Example: If the patient had a total of 4-6 antepartum visits, then the physician should report CPT code 59425 with from and to dates for which the services occurred.
- CPT 59425 and 59426 – These codes must not be billed together by the same provider for the same beneficiary, during the same pregnancy.
- Pregnancy related E/M office visits must not be billed in conjunction with code 59425 or 59426 by the same provider for the same beneficiary, during the same pregnancy.

Reimbursement to FQHCs and RHCs

Nebraska Total Care will reimburse FQHCs and RHCs in accordance with 471 NAC Chapters 29 and 34. Nebraska Total Care will not enter into alternative reimbursement arrangements with FQHCs or RHCs, if initiated by the FQHC or RHC, without prior approval from MLTC.

If Nebraska Total Care is unable to contract with an FQHC or RHC within PCP access distance standards provided by MLTC, Nebraska Total Care is not required to reimburse that FQHC or RHC for out-of-network services without prior approval unless:

- The medically necessary services are required to treat an emergency medical condition.
- FQHC/RHC services are not available through a minimum of one (1) MCO within MLTC's established travel standards.

Nebraska Total Care may stipulate that reimbursement is contingent on receiving a clean claim and all medical information required to update the member's medical record.

Referring/Ordering Physician Requirements

When submitting professional service claims for PT/OT/ST, DME and Hearing Aid services on HCFA 1500 forms, the Nebraska Medicaid regulatory billing guidance requires the identification of the referring/ordering physician on the claim form (Box 17 on a HCFA 1500).

This guidance does not apply to these services when they are billed for a facility on a UB-04 claim form.

The Nebraska Administrative Code (NAC) regulatory billing instructions referencing these requirements can be found by clicking on the following:

- [DME Chapter 471 Billing Instructions](#)
- [Hearing Aid Chapter 471 Billing Instructions](#)
- [PT/OT/ST Chapter 471 Billing Instructions](#)

EAPG

Effective January 1, 2020, Nebraska Total Care will move to acuity based reimbursement, in line with guidance from Nebraska Medicaid and Long-Term Care, for outpatient hospital services using Enhanced Ambulatory Patient Groups (EAPG) methodology. This updated payment approach will not apply to Critical Access Hospitals (CAH's). EAPG is an outpatient visit-based patient classification system designed by 3M and assigns a classification to each claim detail line (574 EAPG's under version 3.14 that will be utilized at implementation).

The base EAPG rates can be viewed on the [DHHS website](#).

There will be no changes in billing hospital outpatient service claims to Nebraska Total Care. All current billing guidelines will continue to be followed for claim submission:

- EAPG payments are made on a per visit basis
- Payment is directed to the main significant procedure or treatment provided during an outpatient visit
- Payment for the main significant procedure considers the average cost of associated ancillary services
- Methodology uses packaging and bundling of payment for related services to create incentives that are consistent with providing services in the most efficient way
- Payment is concentrated on the main procedure, rather than diluting the payment across multiple ancillary services
- It is possible for multiple EAPG payments to be made for the same visit

Appendix I: Instructions for Supplemental Information

CMS-1500 (2/12) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS-1500 (2/12) form field 24A-G:

- Narrative description of unspecified/miscellaneous/unlisted codes
- National Drug Codes (NDC) for drugs (Note: all providers must submit NDC data even if they hold 340b status.)
- Contract Rate

The following qualifiers are to be used when reporting these services:

- ZZ Narrative description of unspecified/miscellaneous/unlisted codes
- N4 National Drug Codes (NDC)
- CTR Contract Rate

The following qualifiers are to be used when reporting NDC units:

- F2 International Unit
- GR Gram
- ME Milligram
- ML Milliliter
- UN Unit

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three (3) blank spaces and then the next qualifier and number/code/information.

For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollars signs (ex. 1000.00; 123.45).

Unspecified/Miscellaneous/Unlisted Codes

| 24. A. | DATE(S) OF SERVICE | | | | | | B. | C. | D. PROCEDURES, SERVICES, OR SUPPLIES | | | | E. | F. | | G. | H. | I. | J. | |
|--------|--------------------|----|----|------|----|----|------------------|-----|-------------------------------------------------------|----------|--|--|-------------------|------------|-----|---------------|--------------------|-----------|--------------------------|-------------|
| | From | To | | From | To | | PLACE OF SERVICE | EMG | (Explain Unusual Circumstances) | | | | DIAGNOSIS POINTER | \$ CHARGES | | DAYS OR UNITS | EP/SOT Family Plan | ID. QUAL. | RENDERING PROVIDER ID. # | |
| MM | DD | YY | MM | DD | YY | | | | CPT/HCPCS | MODIFIER | | | | | | | | | | |
| | | | | | | | | | ZZLaparoscopic Ventral Hernia Repair Op Note Attached | | | | | | | | | | NPI | |
| | | | | | | | | | ZZKaye Walker | | | | | | | | | N | G2 | 12345678901 |
| 10 | 01 | 05 | 10 | 01 | 05 | 11 | | | E1399 | | | | 12 | | 165 | 00 | 1 | N | NPI | 0123456789 |

NDC Codes

| 24. A. | DATE(S) OF SERVICE | | | | | | B. | C. | D. PROCEDURES, SERVICES, OR SUPPLIES | | | | E. | F. | | G. | H. | I. | J. | |
|--------|--------------------|----|----|------|----|----|------------------|-----|--------------------------------------|----------|--|--|-------------------|------------|-----|---------------|--------------------|-----------|--------------------------|-------------|
| | From | To | | From | To | | PLACE OF SERVICE | EMG | (Explain Unusual Circumstances) | | | | DIAGNOSIS POINTER | \$ CHARGES | | DAYS OR UNITS | EP/SOT Family Plan | ID. QUAL. | RENDERING PROVIDER ID. # | |
| MM | DD | YY | MM | DD | YY | | | | CPT/HCPCS | MODIFIER | | | | | | | | | | |
| | | | | | | | | | N459148001665 UN1 | | | | | | | | | N | G2 | 12345678901 |
| 10 | 01 | 05 | 10 | 01 | 05 | 11 | | | J0400 | | | | 1 | | 250 | 00 | 40 | N | NPI | 0123456789 |

Appendix II: Instructions for Submitting NDC Information

Instructions for Entering the NDC

Use the guidelines noted below for all claim types including Web Portal submission. All providers must submit NDC data, even if they hold 340b status. CMS requires the 11-digit National Drug Code (NDC), therefore, providers are required to submit claims with the exact NDC that appears on the actual product administered, which can be found on the vial of medication. The NDC must include the NDC Unit of Measure and NDC quantity/units. When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug.

Table - 837I/837P

| 837I/837P Data Element | Loop | Segment/Element |
|------------------------|------|-----------------|
| NDC | 2410 | LIN03 |
| Unit of Measure | 2410 | CTP05-01 |
| Unit Price | 2410 | CTP03 |
| Quantity | 2410 | CTP04 |

For Electronic submissions, this is highly recommended and will enhance claim reporting/adjudication processes, report in the LIN segment of Loop ID-2410.

Table - Paper Claim Type

| Paper Claim Type | Field |
|------------------|--------------------------|
| CMS-1500 (02/12) | 24 A (shaded claim line) |
| UB-04 | 43 |

Facility

Paper, use Form Locator 43 of the CMS-1450 and UB-04 (with the corresponding HCPCS code in Locator 44) for Outpatient and Facility Dialysis Revenue Codes 250-259 and 634-636.

Physician

Paper, use the red shaded detail of 24A on the CMS-1500 line detail.

Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.

The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code. The middle four digits are the product code. The last two digits are the package size. If you are given an NDC that is less than 11 digits, add the missing digits as follows:

- For a 4-4-2 digit number, add a 0 to the beginning
- For a 5-3-2 digit number, add a 0 as the sixth digit
- For a 5-4-1 digit number, add a 0 as the tenth digit

Enter the 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
- ME - Milligram
- UN – Unit

Appendix III: CMS-1500 Claims Form Instructions

CMS-1500 (2/12) Claim Form Example



HEALTH INSURANCE CLAIM FORM

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

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> <small>PCA</small> | | <input type="checkbox"/> <small>FECA</small> | |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Member ID#) (Medicaid#) (ID#/Doc#) (Member ID#) (ID#) (ID#)</small> | | 1a. INSURED'S I.D. NUMBER <small>(For Program in Item 1)</small> | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | 3. PATIENT'S BIRTH DATE <small>MM DD YY</small> SEX <input type="checkbox"/> M <input type="checkbox"/> F | |
| 5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) | | 6. PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) | |
| 8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>PLACE (State)</small> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 9. OTHER INSURED'S POLICY OR GROUP NUMBER | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <small>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical & 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.</small> | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE <small>I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</small> | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) <small>QUAL.</small> | | 15. OTHER DATE <small>QUAL.</small> | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY <small>Relate ICD to service line below (IME)</small> | | 22. RESUBMISSION CODE ORIGINAL REF. NO. | |
| 24. A. DATE(S) OF SERVICE <small>From To</small> B. PLACE OF SERVICE <small>EMG</small> C. D. PROCEDURES, SERVICES, OR SUPPLIES <small>(Explain Unusual Circumstances)</small> E. DIAGNOSIS POINTER | | 23. PRIOR AUTHORIZATION NUMBER | |
| 25. FEDERAL TAX ID. NUMBER <small>SSN EIN</small> | | 26. PATIENT'S ACCOUNT NO. | |
| 27. ACCEPT ASSIGNMENT? <small>(For gov't, see back)</small> <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28. TOTAL CHARGE \$ | |
| 29. AMOUNT PAID \$ | | 30. Rev'd for NUCC Use | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER <small>INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small> | | 32. SERVICE FACILITY LOCATION INFORMATION | |
| 33. BILLING PROVIDER INFO & PH # () | | | |

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.

Table - CMS-1500 Form Field Instructions

| 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 | PATIENT'S 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. <u>First line</u> – 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). <u>Second line</u> – In the designated block, enter the city and state. <u>Third line</u> – 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. <u>First line</u> – 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). <u>Second line</u> – In the designated block, enter the city and state. <u>Third line</u> – 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 |
| 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 |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 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 has 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 BENEFIT PLAN | Mark Yes or No. If Yes, complete field's 9a-d and 11c. | R |
| 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 |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 15 | OTHER DATE | <p>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.</p> <p>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)</p> | C |
| 16 | DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | C |
| 17 | NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | <p>Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).</p> <p>*This field is required for PT/OT/ST/DME/Hearing Aid service claims</p> | 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 | <p>Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.</p> <p>*This field is required for PT/OT/ST/DME/Hearing Aid service claims</p> | C |
| 18 | HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | C |
| 19 | RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION | | C |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| 20 | OUTSIDE LAB / CHARGES | | 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 | <p>Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM 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.</p> <p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM</p> | R |
| 22 | RESUBMISSION CODE / ORIGINAL REF. NO. | <p>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</p> | C |
| 23 | PRIOR AUTHORIZATION NUMBER or CLIA NUMBER | <p>Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization.</p> <p>CLIA number for CLIA waived or CLIA certified laboratory services.</p> | If auth = C If CLIA = R (If both, always submit the CLIA number) |
| 24a-j | GENERAL INFORMATION | <p>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. (continued on next page)</p> | |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|----------------------|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 24a-j (continued) | GENERAL INFORMATION (continued) | <p>The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number.</p> <p>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.</p> <p>The un-shaded area of a claim line is for the entry of claim line item detail.</p> | |
| 24 A-G Shaded | SUPPLEMENTAL INFORMATION | <p>The shaded top portion of each service claim line is used to report supplemental information for:</p> <p>NDC Narrative description of unspecified codes Contract Rate For detailed instructions and qualifiers refer to Appendix III of this guide.</p> | 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 | <p>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.</p> <p>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.</p> | R |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 24 E Unshaded | DIAGNOSIS CODE | <p>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 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.</p> <p>This field allows for the entry of 4 characters in the unshaded area.</p> | R |
| 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# | <p><u>Typical Providers:</u> Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code.</p> <p><u>Atypical Providers:</u> Enter the Provider ID number.</p> | R |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|------------------|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 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 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. | C |
| 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 |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 30 | BALANCE DUE | <p>REQUIRED when field 29 is completed.</p> <p>Enter the balance due (total charges minus the amount of payment received from the primary payer).</p> <p>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.</p> | C |
| 31 | SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS | <p>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.</p> <p>Note: Does not exist in the electronic 837P.</p> | R |
| 32 | SERVICE FACILITY LOCATION INFORMATION | <p>REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.)</p> <p><u>First line</u> – Enter the business/facility/practice name.</p> <p><u>Second line</u>– 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).</p> <p><u>Third line</u> – In the designated block, enter the city and state.</p> <p><u>Fourth line</u> – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.</p> | C |
| 32a | NPI – SERVICES RENDERED | <p>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.</p> | C |
| 32b | OTHER PROVIDER ID | <p>REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p><u>Typical Providers:</u> Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces).</p> <p><u>Atypical Providers:</u> Enter the 2-character qualifier ID (no spaces).</p> | C |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 33 | BILLING PROVIDER INFO & PH# | <p>Enter the billing provider's complete name, address (include the zip + 4 code), and phone number.</p> <p><u>First line</u> -Enter the business/facility/practice name.</p> <p><u>Second line</u> -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).</p> <p><u>Third line</u> -In the designated block, enter the city and state.</p> <p><u>Fourth line</u>- 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).</p> <p>NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.</p> | R |
| 33a | GROUP BILLING NPI | Enter the 10-character NPI ID. | R |
| 33b | GROUP BILLING OTHERS ID | <p>Enter as designated below the Billing Group taxonomy code.</p> <p><u>Typical Providers:</u> Enter the Provider Taxonomy Code. Use ZZ qualifier.</p> <p><u>Atypical Providers:</u> Enter the Provider ID number.</p> | R |

Appendix IV – UB-40 Claims Form Instructions

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 Comprehensive Outpatient Rehabilitation Facilities (CORF), 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

The image shows a sample UB-04 form with the following sections filled out:

- Header:** Includes fields for ICD-9-CM diagnosis code (01), ICD-9-CM procedure code (02), and patient name (03).
- Demographics:** Fields for patient name (04), address (05), and birth date (06).
- Insurance:** Fields for health plan ID (07), policy number (08), and group name (09).
- Procedure Table:** A large table with columns for description (43), ICD-9-CM code (44), date (45), units (46), total charges (47), and non-covered charges (48).
- Summary:** A section at the bottom with a 'TOTALS' arrow pointing to the right, containing fields for total charges (50) and non-covered charges (51).

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.

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

Table - UB-04 Form Field Instructions

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 1 | UNLABELED FIELD | LINE 1: Enter the complete provider 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 |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 8b | PATIENT NAME | <p>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.</p> <p><u>Titles:</u> (Mr., Mrs., etc.) should not be reported in this field.</p> <p><u>Prefix:</u> No space should be left after the prefix of a name (e.g. McKendrick. H).</p> <p><u>Hyphenated names:</u> Both names should be capitalized and separated by a hyphen (no space).</p> <p><u>Suffix:</u> a space should separate a last name and suffix. Enter the patient’s complete mailing address of the patient.</p> | R |
| 9 | PATIENT ADDRESS | <p>Enter the patient’s complete mailing address of the patient.</p> <p>Line a: Street address Line b: City Line c: State Line d: Zip code Line e: Country Code (NOT REQUIRED)</p> | 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 | <p>Enter the date of admission for inpatient claims and date of service for outpatient claims.</p> <p>Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.</p> | R |
| 13 | ADMISSION HOUR | <p>Enter the time using 2 digit military times (00-23). 00- 12:00 midnight to 12:59</p> <p>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 (continued on next page)</p> | R |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|-------------------|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 13 (continued) | ADMISSION HOUR (continued) | 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 5 Trauma | R |
| 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 | R |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 16 | DISCHARGE HOUR | <p>Enter the time using 2 digit military times (00-23) for the time of the inpatient or outpatient discharge.</p> <p>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</p> | C |
| 17 | PATIENT STATUS | <p>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:</p> <p>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 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 (continued on next page)</p> | R |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|-------------------|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 17 (continued) | PATIENT STATUS (continued) | 30 Still patient (To be used only when the client has been in the facility for 30 consecutive 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 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. | C |
| 29 | ACCIDENT STATE | | Not Required |
| 30 | UNLABELED FIELD | Not Used. | Not Required |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|-----------|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 31-34 a-b | OCCURRENCE CODE and OCCURRENCE DATE | <p>Occurrence Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>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.</p> | C |
| 35-36 a-b | OCCURRENCE SPAN CODE and OCCURRENCE DATE | <p>Occurrence Span Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>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.</p> | 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 |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
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| 39-41 a-d | VALUE CODES and AMOUNTS | <p>Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>Up to 12 codes can be entered. All “a” fields 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.</p> <p>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 right 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.</p> | C |
| 42-47 General Information Fields | SERVICE LINE DETAIL | <p>The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information.</p> <p>Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.</p> | |
| 42 Line 1-22 | Rev CD | <p>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.</p> <p>Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.</p> | 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 |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
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| 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 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. | C |
| 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 |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 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 directly to the provider for services. | R |
| 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 |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 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 |
| 67 | PRINCIPAL DIAGNOSIS CODE | Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-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-9/10-CM Volume 1 & 3 for the date of service. 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" 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 |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|----------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 69 | ADMITTING DIAGNOSIS CODE | <p>Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1 & 3 for the date of service.</p> <p>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” are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied.</p> | R |
| 70 | PATIENT REASON CODE | <p>Enter the ICD-9/10-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.</p> <p>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” are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied.</p> | 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 |
| 73 | UNLABELED | | Not Required |
| 74 | PRINCIPAL PROCEDURE CODE/DATE | <p>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.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p> | C |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|---------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 74 a-e | OTHER PROCEDURE CODE DATE | <p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>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.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p> | C |
| 75 | UNLABELED | | Not Required |
| 76 | ATTENDING PHYSICIAN | <p>Enter the NPI and name of the physician in charge of the R patient care.</p> <p>NPI: Enter the attending physician 10-character NPI ID.</p> <p>Taxonomy Code: Enter valid taxonomy code.</p> <p>QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code.</p> <p>LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.</p> | R |
| 77 | OPERATING PHYSICIAN | <p>REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care.</p> <p>NPI: Enter the attending physician 10-character NPI ID.</p> <p>Taxonomy Code: Enter valid taxonomy code.</p> <p>QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code.</p> <p>LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.</p> | C |

| Field # | Field Description | Instructions or Comments | Required or Conditional |
|---------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 78 & 79 | OTHER PHYSICIAN | <p>Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care.</p> <p>(Blank Field): Enter one of the following Provider Type Qualifiers:</p> <p>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</p> | C |
| 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 |