471-000-64 Nebraska Medicaid Billing Instructions for Mental Health and Substance Abuse Services

The instructions in this appendix apply when billing Nebraska Medicaid, also known as the Nebraska Medical Assistance Program (NMAP), for Medicaid-covered services provided to clients who are eligible for fee-for-service Medicaid or enrolled in the Nebraska Medicaid Mental Health/Substance Abuse Managed Care Program.

CMS 1500 Claim Form Versions

> In November, 2013, Nebraska Medicaid published implementation information regarding the revised CMS 1500 claim form (version 02/12). The transition timeline for dual processing and acceptance of ONLY the CMS 1500 claim form (version 02/12) may be found in that Provider Bulletin 13-75 at this site:
> http://dhhs.ne.gov/medicaid/Documents/pb1375.pdf

> Please note that on or after **April 1, 2014**, any claims received utilizing the older versions of the CMS 1500 claim form will be returned to the provider.

Medicaid regulations for mental health and substance abuse services are covered in 471 NAC 20-000, 471 NAC 32-000 and 471-NAC 35-000. For a listing of billing instructions for all Medicaid services, see 471-000-49.

Third Party Resources: Claims for services provided to clients with third party resources (e.g., Medicare, private health/casualty insurance) must be billed to the third party payer according to the payer's instructions. After the payment determination by the third party payer is made, the provider may submit the claim to Nebraska Medicaid. A copy of the explanation of benefits, remittance advice, denial, or other documentation from the third party resource must be submitted with the claim.

For instructions on billing Medicare crossover claims, see 471-000-70.

Verifying Eligibility: Medicaid eligibility, managed care participation, and third party resources may be verified from –

1. The client's permanent Nebraska Medicaid Identification Card or temporary Nebraska Medicaid Presumptive Eligibility Application. For explanation and examples, see 471-000-123;
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
3. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

CLAIM FORMATS

Electronic Claims:

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- Community-based (non-hospital) and supervising practitioner mental health and substance abuse services are billed to Nebraska Medicaid using the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

- Hospital-based mental health and substance abuse services are billed to Nebraska Medicaid using standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

Paper Claims:

- Community-based (non-hospital) and supervising practitioner mental health and substance abuse services are billed to Nebraska Medicaid on Form CMS-1500, "Health Insurance Claim Form." Instructions for completing Form CMS-1500 are in this appendix.

- Hospital-based mental health and substance abuse services are billed to Nebraska Medicaid on Form CMS-1450, "Health Insurance Claim Form." Instructions for completing Form CMS-1450 are in this appendix.

Share of Cost Claims: Certain Medicaid clients are required to pay or obligate a portion of their medical costs due to excess income. These clients receive Form EA-160, "Record of Health Cost – Share of Cost – Medicaid Program" from the HHS office to record services paid or obligated to providers. For an example and instructions on completing this form, see 471-000-79.

MEDICAID CLAIM STATUS

The status of Nebraska Medicaid claims can be obtained by using the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277). For electronic transaction submission instructions, see 471-000-50.

Providers may also contact Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln) from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Remittance Advice and Refund Report

The Remittance Advice and Refund Requests report contains information on Medicaid processed claims (paid or denied), adjusted claims and requested refunds. A report is sent weekly when there is reportable activity. For detailed information see 471-000-85 in the provider handbook. See Web site for national code information: http://www.wpc-edi.com/codes/codes.asp.

CMS-1500 FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims on Form CMS-1500, retain a duplicate copy and mail the ORIGINAL form to –

Medicaid Claims Unit
Division of Medicaid and Long-Term Care
Department of Health and Human Services
P. O. Box 95026
Lincoln, NE 68509-5026

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Claim Example: See 471-000-58 for an example of Form CMS-1500.

Claim Form Completion Instructions: The numbers listed below correspond to the numbers of the fields on the form. Completion of fields identified with an asterisk (*) is mandatory for claim acceptance. Information in fields without an asterisk is required for some aspect of claims processing/resolution. Fields that are not listed are not needed for Nebraska Medicaid claims.

*1a.   INSURED'S I.D. NUMBER: Enter the Medicaid client's complete eleven-digit identification number (Example: 123456789 01).

 *2.   PATIENT'S NAME: Enter the full name (last name, first name, middle initial) of the person that received services.

 *3.   PATIENT'S BIRTHDATE AND SEX: Enter the month, day, and year of birth of the person that received the service. Check the appropriate box (M or F).

9. – 11. Fields 9-11 address third party resources other than Medicare and Medicaid. If there is no known coverage, leave blank. If the client has insurance coverage other than Medicaid or Medicare, complete fields 9-11.   A copy of the remittance advice, explanation of benefits, denial, or other documentation is required and must be attached to the claim. Nebraska Medicaid must review all claims for possible third party reimbursement. All third party resources must be exhausted before Medicaid payment may be issued.

 *14.   DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY: When billing for psychiatric residential treatment facility, therapeutic group home and professional resource family care services, enter the admission date.

 17.   NAME OF PROVIDER OR OTHER SOURCE: For consultations, enter the name of the referring/prescribing physician/practitioner.

 17a.   OTHER ID#: Leave qualifier field blank. Effective 01/01/2012, this field is no longer required.

 17b.   NPI#: Effective 01/01/2012, for consultations, enter the National Provider Identifier (NPI) of the referring/prescribing physician/provider.

 18.   HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: Complete only when billing for services provided to a client during a hospital inpatient stay. Enter the date of hospital admission and, if known, the dates of hospital discharge.

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

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

20.   OUTSIDE LAB: Leave blank.

        CHARGES: Leave blank.

*21.   DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: The services reported on this claim form must be related to the diagnosis entered in this field. Enter the appropriate International Classification of Disease, Clinical Modification diagnosis codes. Do not use codes from the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association.

        The COMPLETE diagnosis code is required.

        CMS 1500 claim form (version 08-05) will be accepted through March 31, 2014. For claims being submitted on this version there are up to four diagnoses that may be entered in 1-4. If there is more than one diagnosis, list the primary diagnosis first.

        CMS 1500 claim form (version 02-12) is currently accepted. For dates of service on or before September 30, 2015 only ICD-9 codes will be accepted on this form. For dates of service on or after October 1, 2015 only ICD-10 codes will be accepted.

        For claims being submitted on the CMS 1500 claim form (version 02-12) there are up to twelve diagnoses that may be entered in A-L. If there is more than one diagnosis, list the primary diagnosis first.

        ICD VERSION INDICATOR: On the CMS 1500 (version 02/12) the **ICD Version Indicator is required**. The ICD qualifier located in this section denotes the version of International Classification of Diseases reported.

        The ICD Version Indicator will be used to distinguish if the submitted Code is an ICD-9 or an ICD-10 Code.

        Version '9' indicates the Codes entered as ICD-9 Diagnosis Code.

        Version '0' indicates the Codes entered as ICD-10 Diagnosis Code.

22.   MEDICAID RESUBMISSION: Leave blank. For regulations regarding resubmittals or payment adjustment requests, see 471 NAC 3-000 and 471-000-99.

*23.   PRIOR AUTHORIZATION NUMBER: For services that require prior authorization, the nine-digit prior authorization number MUST be entered in Field 23. Note: Only one prior authorization number can be entered on each claim.

*24.   The six service lines in section 24 have been divided horizontally to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 services lines. Only six line items can be entered in Field 24. Do not print more than one line of information on each claim line. DO NOT LIST services for which there is no charge.

*24A.   DATE(S) OF SERVICE: In the unshaded area, enter the 8-digit numeric date of service rendered. Each procedure code/service billed requires a date (MMDDCCYY).

        The following services may be billed on a single claim line when the service dates are consecutive and the procedure is the same each day: Inpatient physician services and PRTF. When billing for consecutive dates, enter the begin date (From) and end date (To).

        Partial hospitalization cannot be billed consecutively and must be billed on separate lines. When billing non-consecutive days, only the begin date (From) must be entered and each service must be listed on a separate line.

*24B.   PLACE OF SERVICE: In the unshaded area, enter the national two-digit place of service code that describes the location of the service that was rendered. National place of service codes are defined by the Centers for Medicare and Medicaid Services (CMS) and published on the CMS web site at https://www.cms.gov/. The most common national place of service codes are -

        01 Pharmacy
        03 School
        04 Homeless Shelter
        05 Indian Health Service Free-standing Facility
        06 Indian Health Service Provider-based Facility
        07 Tribal 638 Free-standing Facility
        08 Tribal 638 Provider-based Facility
        09 Prison – Correctional Facility
        11 Office
        12 Home
        13 Assisted Living Facility
        14 Group Home
        15 Mobile Unit

        20 Urgent Care Facility
        21 Inpatient Hospital
        22 Outpatient Hospital
        23 Emergency Room – Hospital
        24 Ambulatory Surgical Center
        25 Birthing Center
        26 Military Treatment Facility
        31 Skilled Nursing Facility
        32 Nursing Facility
        33 Custodial Care Facility

34 Hospice
41 Ambulance – Land
42 Ambulance – Air or Water
49 Independent Clinic
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility-Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
57 Non-residential Substance Abuse Treatment Facility
60 Mass Immunization Clinic
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End-Stage Renal Disease Treatment Facility
71 Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Place of Service

*24D.   PROCEDURES, SERVICES, OR SUPPLIES: In the unshaded area, enter the appropriate CPT or HCPCS Level II procedure code and, if required, procedure code modifier. Up to four modifiers may be entered for each procedure code, including NCCI modifiers, if appropriate.   Procedure codes and modifiers used by the Nebraska Medicaid Mental Health Substance Abuse Program are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).

*24E.   DIAGNOSIS POINTER:
Version (02/12) On the CMS 1500 claim form list the reference letter of the primary diagnosis that is being treated from Field 21 (A-L). Up to four diagnosis pointers may be entered per line.

Version (08/05) On the CMS 1500 claim form list the reference number of the primary diagnosis that is being treated from Field 21 (1-4). On the CMS 1500 claim form (version 02-12) list the reference letter of the primary diagnosis that is being treated from Field 21 (A-L). One diagnosis pointer may be entered per line.

*24F. $ CHARGES: Enter your customary charge for each procedure code. Each procedure code must have a separate charge. Payment for services will be made on the basis of the Nebraska Medical Assistance Program's payment methodology.

*24G.   DAYS OR UNITS: Enter the number of services being claimed. Some procedure codes are time specific. If the procedure code description includes specific time or quantity increments, each increment should be billed as one unit of service, not by minute. For example, procedure code H2015-HE (Community Support – Mental Health) is defined as a 15 minute unit. When billing this service for a half hour, the correct unit of service is "2", not the number of minutes.

*24J.   RENDERING PROVIDER ID#: **Healthcare Providers**: Complete only if enrolled with Nebraska Medicaid as a group provider. Effective 01/01/2012, enter the National Provider Identifier (NPI) of the rendering provider. Only one service rendering provider may be reported per claim.

   Atypical Providers: See #25.

*25.   FEDERAL TAX I.D. NUMBER: **Atypical Providers*:** Complete only if enrolled with Nebraska Medicaid as a group provider. Enter the Social Security Number of the practitioner providing the service identified on this claim (Service Rendering Provider Number). Only one service rendering provider number may be reported per claim.

   *Atypical Providers (Not Eligible for NPI): Nebraska Medicaid defines "atypical providers" as: MHCP (Medically Handicapped Children's Program) clinics, MIPS (Medicaid in Public Schools), Personal Care Aides, Mental Health Personal Care Aides/Community Treatment Aides, Mental Health Home Health Care Aides, Non-Emergency Transportation providers and Community Support Workers. **However, please note, effective March 1, 2022, with the exception of Non-Emergency Transportation providers, all other provider types listed above will be required to have an NPI in order to enroll and participate in Nebraska Medicaid.**

   Healthcare Providers: Effective 01/01/2012, this field is no longer required. See #24J.

26.   PATIENT'S ACCOUNT NO.: Optional. Any patient account information (numeric or alpha) may be entered in this field to enhance patient identification. This information will appear on the Medicaid Remittance Advice.

*28.   TOTAL CHARGE: Enter the total of all charges in Field 24, Column F. If more than one claim form is used to bill for services provided, EACH claim form must be submitted with the line items totaled. DO NOT carry charge forward to another claim form.

*29.   AMOUNT PAID: Enter any payments made, due, or obligated from other sources for services listed on this claim unless the source is from Medicare. Other sources may include health insurance, liability insurance, excess income, etc. A copy of the Medicare or insurance remittance advice, explanation of benefits, denial, or other documentation must be attached to each applicable claim when submitting multiple claim forms. DO NOT enter previous Medicaid payments, Medicare payments or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount) in this field.

*30.   Version (02/12) RSVD FOR NUCC USE

   Version (08/05) BALANCE DUE: Provider may enter the balance due. (This amount is determined by subtracting the amount paid in Field 29 from the total charge in Field 28.)

*31.   SIGNATURE OF PHYSICIAN OR SUPPLIER: The provider or authorized representative must SIGN and DATE the claim form. A signature stamp, computer-generated or typewritten signature will be accepted. The signature date must be on or after the dates of service listed on the form.

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*32.   SERVICE FACILITY LOCATION INFORMATION: Enter the name and address of the facility where services were rendered if other than home or office. Example: school, nursing home, group home.

32a.   NPI#: Not used.

32b.   OTHER ID #: Not used.

33.   BILLING PROVIDER INFO & PH#: Enter the provider's name, address, nine-digit zip code, and phone number. Each provider location must be enrolled separately.

    *Effective 01/01/2012, enter the nine-digit Zip Code (Zip+4) of the Billing Provider, as reported to Nebraska Medicaid.

*33a.   NPI#: **Healthcare Providers:** Effective 01/01/2012, enter the National Provider Identifier (NPI) of the Billing Provider, as reported to Nebraska Medicaid.

    Atypical Providers*: Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (example: 123456789-12).

    *Atypical Providers (Not Eligible for NPI): Nebraska Medicaid defines "atypical" providers as: MHCP (Medically Handicapped Children's Program) clinics, MIPS (Medicaid in Public Schools), Personal Care Aides, Mental Health Personal Care Aides/Community Treatment Aides, Mental Health Home Health Care Aides, Non-Emergency Transportation providers and Community Support Workers. **However, please note, effective March 1, 2022, with the exception of Non-Emergency Transportation providers, all other provider types listed above will be required to have an NPI in order to enroll and participate in Nebraska Medicaid.**

*33b.   OTHER ID#: **Healthcare Providers:** Effective 01/01/2012, enter the 10-digit Taxonomy Code of the Billing Provider, as reported to Nebraska Medicaid.

    Atypical Providers: Not required. See #33a for definition.

CMS-1450 FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims on Form CMS-1450, retain a duplicate copy and mail the ORIGINAL form to –

    Medicaid Claims Unit
    Division of Medicaid and Long-Term Care
    Department of Health and Human Services
    P. O. Box 95026
    Lincoln, NE 68509-5026

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Claim Example: See 471-000-51 for an example of Form CMS-1450.

Claim Form Completion Instructions: CMS-1450 (UB-04) completion requirements for Nebraska Medicaid are outlined below. The numbers listed correspond to the CMS-1450 form locators (FL) and are identified as required, situational, recommended or not used. For a summary of form locator requirements for all services, see 471-000-78.

These instructions must be used with the complete CMS-1450 (UB-04) claim form completion instructions outlined in the National Uniform Billing Committee Data Specifications Manual. The National Uniform Billing Committee Data Specifications Manual is available through the Nebraska Hospital Association. Order information is at:
http://www.nhanet.org/data_information/ub04.htm

FL	DATA ELEMENT DESCRIPTION	REQUIREMENT
1.	**Provider Name, Address & Telephone Number**	**Required**
	Each provider location must be enrolled separately.	
2.	**Pay-to Name and Address**	**Situational**
3a.	**Patient Control Number**	**Required**
	The patient control number will be reported on the Medicaid Remittance Advice.	
3b.	**Medical/Health Record Number**	**Situational**
	The number assigned to the patient's medical/health record by the provider.	
4.	**Type of Bill**	**Required**
5.	**Federal Tax Number**	**Required**
6.	**Statement Covers Period**	**Required**
7.	**Reserved for Assignment by the NUBC**	**Not Used**
8.	**Patient Name/Identifier**	**Required**
	The patient is the person that received services.	
9.	**Patient Address**	**Required**
10.	**Patient Birthdate**	**Required**
	The patient is the person who received the services.	
11.	**Patient Sex**	**Required**
12.	**Admission/Start of Care Date**	

Required on all inpatient claims. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy.

| 13. | **Admission Hour** | **Situational** |

Required on all inpatient claims. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy.

| 14. | **Priority (Type of Visit)** | **Situational** |

A code indicating the priority of this type of visit. Required on all inpatient claims.

| 15. | **Source of Referral for Admission or Visit** | **Required** |

The patient is the person that received services.

| 16. | **Discharge Hour** | **Situational** |

Required on all inpatient claims.

| 17. | **Patient Discharge Status** | **Situational** |

Required on all inpatient claims. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy.

| 18-28. | **Condition Codes** | **Situational** |

Use if applicable

| 29. | **Accident State** | **Not Used** |

| 30. | **Reserved for National Assignment by the NUBC** | **Not Used** |

| 31-34. | **Occurrence Codes and Dates** | **Situational** |

Required for traumatic diagnoses. Required on outpatient claims for emergency rooms, observation rooms, and electroconvulsive therapy. Use other occurrence codes if applicable.

| 35-36. | **Occurrence Span Codes and Dates** | **Situational** |

A code and related dates that identify an event that relates to payment of the claim. These codes identify occurrences that happened over a span of time.

| 37. | **Reserved for National Assignment by the NUBC** | **Not Used** |

| 38. | **Responsible Party Name and Address** | **Situational** |

Use if applicable.

39-41. Value Codes and Amounts   **Situational**

Use value code 80 to report covered days, 81 to report non-covered days, 82 to report co-insurance days, and 83 to report lifetime reserve days.

42.   Revenue Code   **Required**

43.   Revenue Description   **Required**

44.   HCPCS/Rates/HIPPS Rate Codes   **Situational**

HCPCS procedure codes are required on all mental health/substance abuse claims, except pharmacy and supplies. Procedure codes and modifiers used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532). Up to four procedure code modifiers may be entered for each procedure code including NCCI modifiers, if appropriate.

Rates are required on acute psychiatric inpatient claims for accommodation rooms.

45.   Service Date   **Situational**

Required on outpatient claims with date spans (FL6) greater than one calendar day, except dialysis, cardiac rehab, and ambulatory room and board services.

46.   Units of Service   **Required**

Units must be whole numbers. No decimals or fractions are permitted.

47.   Total Charges (by Revenue Code Category)   **Required**

Total charges must be greater than zero. Do not submit negative amounts.

48.   Non-Covered Charges   **Situational**

Enter only Nebraska Medicaid non-covered charges. Do not submit negative amounts.

50.   Payer Name   **Situational**

51.   Health Plan Identification Number   **Situational**

52.   Release of Information Certification Indicator   **Not Used**

53.   Assignment of Benefits Certification Indicator   **Not Used**

54.   Prior Payments - Payers and Patient   **Situational**

Enter any payments made, due, or obligated from other sources for services listed on this claim unless the source is from Medicare. Other sources may include health insurance, liability insurance, excess income, etc. A copy of the explanation of Medicare or insurance remittance advice, explanation of benefits, denial, or other documentation must be attached to each claim when submitting multiple claim forms.

DO NOT enter previous Medicaid payments, Medicaid copayment amounts, Medicare payments, or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount).

55.   Estimated Amount Due   **Not Used**

56.   National Provider Identifier – Billing Provider   **Situational**

Healthcare Providers: Effective 01/01/2012, enter the <u>National Provider Identifier (NPI)</u> of the Billing Provider, as reported to Nebraska Medicaid.

Atypical Providers: See FL 57.

57.   Other Provider Identifier   **Situational**

Healthcare Providers: Effective 01/01/2012, this field is no longer required.

Atypical Providers*:   Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (example: 123456789-12).

*<u>Atypical Providers</u> (Not Eligible for NPI): Nebraska Medicaid defines "atypical" providers as: MHCP (Medically Handicapped Children's Program) clinics, MIPS (Medicaid in Public Schools), Personal Care Aides, Mental Health Personal Care Aides/Community Treatment Aides, Mental Health Home Health Care Aides, Non-Emergency Transportation providers and Community Support Workers. **However, please note, effective March 1, 2022, with the exception of Non-Emergency Transportation providers, all other provider types listed above will be required to have an NPI in order to enroll and participate in Nebraska Medicaid.**

58.   Insured's Name   **Not Used**

59.   Patient's Relationship to Insured   **Required**

Use patient relationship code 18 for all claims.

60.   Insured's Unique Identification   **Required**

Enter the Medicaid client's complete eleven-digit identification number (example: 123456789-01).

61.   (Insured) Group Name   **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

62.   Insurance Group Number   **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

63.   Treatment Authorization Code   **Situational**

Required on all inpatient claims. Required on outpatient claims for partial hospitalization. Required for outpatient therapy services for clients participating in the Nebraska Medicaid mental health/substance abuse managed care plan.

64.   Document Control Number (DCN)   **Situational**

Required when Type of Bill Frequency Code (FL04) indicates this claim is a replacement claim or void to a previously adjudicated claim.

65.   Employer Name of the Insured   **Not Used**

66.   Diagnosis and Procedure Code Qualifier (ICD Version Indicator)   Required

The qualifier denotes the version of International Classification of Diseases reported.

The ICD Version Indicator will be used to distinguish if the submitted Code is an ICD-9 or an ICD-10 Code.

Version '9' indicates the Codes entered as ICD-9 Diagnosis or Surgical Procedure Code.

Version '0' indicates the Codes entered as ICD-10 Diagnosis or Surgical Procedure Code.

67.   Principal Diagnosis Code   **Required**

Enter the International Classification of Diseases-Clinical Modification (ICD-CM) describing the principal/primary diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care). The COMPLETE diagnosis code is required, as defined in ICD-CM.

67A-Q. Other Diagnosis Codes ICD--CM   **Situational**

Required if more than one diagnosis applies to the services on this claim.

Enter POA indicator for secondary Diagnosis code in shaded region, unless exempt from reporting.

68.   Reserved for National Assignment by the NUBC   **Not Used**

69.   Admitting Diagnosis   **Situational**

Required on all inpatient claims. Required on outpatient claims for emergency room services.

70a-c. Patient's Reason for Visit   **Situational**

71.   Prospective Payment System (PPS) Code   **Not Used**

72. **ICD-9 External Cause of Injury Code (E-Code)**   **Situational**

ICD-10 External Causes of Morbidity (V, W, X or Y Code)   **Situational**

Required if the principal diagnosis is trauma.

Enter POA indicator for the external cause of injury code in shaded region of A-C, unless exempt from reporting.

73. **Reserved for National Assignment by the NUBC**   **Not Used**

74. **Principal Procedure Code and Date**   **Not Used**

74a-e. Other Procedure Codes and Dates   **Not Used**

75. **Reserved for National Assignment by the NUBC**   **Not Used**

76. **Attending Provider Name and Identifiers**   **Required**

Enter the attending practitioner's last and first name.

Effective 01/01/2012, enter the National Provider Identifier (NPI) of the attending practitioner.

77. **Operating Physician Name and Identifiers**   **Not Used**

78-79. Other Provider Names and Identifiers   **Not Used**

80. **Remarks**   **Situational**

Use to explain unusual services and to document medical necessity, for example, when unit limitations are exceeded. Required for outpatient stays greater than 24 hours.

81. **Code-Code Field**   **Situational**

To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

81cc.a Taxonomy Code of the Billing Provider   **Situational**

 Healthcare Providers: Effective 01/01/2012, enter the 10-digit Taxonomy Code of the Billing Provider, as reported to Nebraska Medicaid.

 Atypical Providers: Not required. See FL57 for definition.

81cc.b. ZIP CODE of the Billing Provider   **Situational**

 Healthcare Providers: Effective 01/01/2012, enter the nine-digit Zip Code (Zip+4) of the Billing Provider, as reported to Nebraska Medicaid.

 Atypical Providers: Not required. See FL57 for definition.