NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

UB-04 Billing Procedures for Assisted Living Facilities

Notification of Medical Absences

The facility must notify the services coordinator or services coordination agency by the next DHHS working day of a medical absence in which a client is admitted to a hospital or nursing facility. This notice is required in order for the Services Coordinator and Central Office to determine the continued appropriateness of the assisted living authorization. Failure to report medical absences to the Services Coordinator by the next DHHS working day may result in DHHS imposing sanctions upon a provider as defined in 471 NAC 2-002.03-04. The facility will also be required to reimburse DHHS for days the client was out of the facility for medical reasons.

Monthly Rate

Monthly rates will be paid to assisted living facilities for all on-going months of service when an individual is physically present during the entire month in the assisted living facility. The monthly rate does not apply to the months of admission ("service begin") and discharge ("service end") or when a facility fails to notify the services coordinator of a medical absence by the next DHHS working day.

Daily Rate

For the months of admission and discharge ("service begin" and "service end"), the facility is paid a daily rate for all days in which the client is physically present after authorization or prior to discharge.

Fixed Cost Allowance Rate

During the months of admission and discharge, if the client is out of the facility for any reason, the facility will receive 90% of the daily rate as a "fixed cost allowance."

Examples:

A. "Service Begin" Month: Client is authorized for the assisted living facility on the 16th day of the month and the client is physically present each day through the last calendar day of the month.
   a. The assisted living facility is paid the contracted daily rate for 16 days (31-day month).

B. "Service Begin" Month: Client is authorized for the assisted living facility on the 16th day of the month and the client is admitted to the hospital (or out of the assisted living facility on a social visit) on the 21st day of the month and returns to the assisted living facility on the 24th day of the month.
   a. Day 1 through 15, no payment to the assisted living facility
   b. Day 16 through 21, the assisted living facility is paid the contracted daily rate
   c. Days 22 & 23 are paid at the 90% daily rate "fixed cost allowance"
   d. Days 24 through the last calendar day of the month, the assisted living facility is paid the contracted daily rate

C. "Service End" Month: Client is physically present in the assisted living facility through the day of discharge on the 16th day of the month.
   a. Days 1 through 16, the assisted living facility is paid the contracted daily rate
   b. No payment following Day 16

D. "Service End" Month: Client is physically present in the assisted living facility for days 1 through 12. The client is hospitalized on day 12 and discharged on the 16th day of the

month.

a. Days 1 through 12,the assisted living facility is paid the contracted daily rate
b. Days 13 through 15, the assisted living facility is paid the 90% daily rate "fixed cost allowance"
c. Day 16 (day of discharge) facility is paid the contracted daily rate
d. No payment following Day 16

Day of Discharge

Providers are paid for the day of discharge.

Level of Care Changes

If the level of care is incorrect, you must contact the services coordinator to have the prior authorization updated.

Paid By Other Sources/Share of Cost

The correct amount of the POS or share of cost must be reflected on the UB-04 in order for the claim to pay.

- For individual Medicaid eligibility questions, contact AccessNebraska.
- For other questions such as share of cost amount, call the customer service inquiry line: 1 (877) 255-3092.

Change of Ownership/Taxonomy Number/NPI/Provider Number

Any changes in ownership, taxonomy number, NPI, or provider number need to reported to the assigned resource development worker for the service area in which the assisted living facility is located. If you are unsure of whom the resource development worker is, contact your local Area Agency on Aging or League of Human Dignity. The resource development worker will instruct the assisted living facility on how to complete the provider enrollment process. Failing to complete the provider enrollment process within a timely manner could result in the loss of payment or a delay in claims processing. Provider agreements are not transferable.

Claim Submission

Claims must be submitted within six months of the date of service.

Claim Adjustments

Initial claims will be returned if information is missing.

Reasons Claims are Denied or Paid Incorrectly:

- Level of care is incorrect (i.e. Rural/Urban, Single/Multiple)
- Number of assisted living days was incorrect
- Hospital/nursing home/therapeutic days are missing or incorrect
- Paid by other source (POS) or share of cost (SOC) amount is incorrect
- Incorrect discharge date on claim

Adjustment Request Procedures for a paper UB-04

- The provider must submit a photocopy of the MCP 248 "Remittance Advice" (the EOB that you receive with your check) with the claim in question indicated.

- Highlight or circle the claim number
    - The claim number can be found to the far right side of the "Remittance Advice" on the same line as the Medicaid client name and number.
- Write a brief explanation on the copy of the "Remittance Advice"
    - Examples: Level of care should have been ___. POS is incorrect. Number of days should have been ___. Discharge date incorrect, should be --/--/--.
- Sign, date and give a phone number of person to contact with questions.

Paper Adjustment Request Procedures for an electronic UB-04

- The provider must submit a photocopy of the ASC X12N 835 "Remittance Advice" (the EOB that you receive with your check) with the claim in question indicated.
- Highlight or circle the claim number
    - The claim number can be found to the far right side of the "Remittance Advice" on the same line as the Medicaid client name and number.
- Write a brief explanation on the copy of the "Remittance Advice"
    - Examples: Level of care should have been ___. POS is incorrect. Number of days should have been ___. Discharge date incorrect, should be --/--/--.
- Sign, date and give a name and phone number of the person to contact with questions.

Mail adjustment requests to:
Department of Health and Human Services (DHHS)
Claims Processing
PO Box 95026
Lincoln, NE 68509-5026

Electronic Adjustment Request procedures

- Must be Frequency Code 7
- Indicate corrections to applicable fields
- Contact EDI for questions regarding problems with submission of electronic adjustments.

Do not re-submit a claim if it was not paid correctly.

An adjustment is always done on the original claim*.

*(unless necessary to submit a different bill type. For example, intitially submitted bill type 663 instead of 664)

Providers are restricted to a maximum time limitation of 90 days to request an adjustment to a claim that has been paid with a portion reduced or disallowed, or a claim that has been disallowed in total, unless documentation of extenuating circumstances is submitted to Medicaid Claims. The 90-day limitation begins with the payment date of the remittance advice.

For questions call:
Inquiry Line Toll Free 1-877-255-3092
or in **Lincoln 402-471-9128**

Nebraska Medicaid Long-Term Care
UB-04 Billing Instructions
For Assisted Living – Waiver

Claims can only be submitted after the end of the month.

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

FL DATA ELEMENT DESCRIPTION	REQUIREMENT

1. Provider Name, Address & Telephone Number — **Required**

4. Type of Bill — **Required**

Use Bill Type code 66X for assisted living Waiver services.
Third digit must correspond to claim frequency code:

1 = Admit through Discharge Claim
2 = Interim – First Claim
3 = Interim – Continuing Claim
4 = Interim – Last Claim
7= Replacement of Prior Claim

5. Federal Tax Number — **Required**

Enter the facility's tax identification number.

6. Statement Covers Period — **Required**

Enter beginning and end claim services dates.
MMDDYY format

8. Patient Name/Identifier — **Required**

The patient is the person who received services.

9. Patient Address — **Required**

The patient address will be the facility address.

10. Patient Birth Date — **Required**

MMDDCCYY format

11. Patient Sex — **Required**

"M" for Male, "F" for Female

12. Admission Date — **Required**

The date the resident was admitted to the facility. MMDDCCYY format.

17. Patient Discharge Status **Situational**

Code indicates the disposition or discharge status of the patient for the period covered by the claim and is required only when patient's stay ends at the facility.

Enter one of the following two-digit codes for the patient's status (as of the "through" date):

01 = Discharged to home or self care (routine discharge)
02 = Discharged/transferred to another short-term general hospital
03 = Discharged/transferred to skilled nursing facility (SNF)
04 = Discharged/transferred to an intermediate care facility (ICF)
05 = Discharged/transferred to another type of institution
06 = Discharged/transferred to home under care of organized home health service organization
07 = Left against medical advice
08 = Reserved
09 = Admitted as an inpatient to this hospital (Medicare Outpatient Only)
20 = Expired (or did not recover – Christian Science patient)
21 – 29 Reserved
30 = Still a patient
40 = Expired at home
41 = Expired in a medical facility; e.g., hospital, SNF, ICF, or free-standing hospice (Medicare Hospice Care Only)
42 = Expired - place unknown (Medicare Hospice Care Only)
43 = Discharged to Federal Health Care Facility
50 = Hospice- Home
51 = Hospice – Medical Facility
52 – 60 Reserved
61 = Discharge to Hospital Based Swing Bed
62 = Discharged to Inpatient Rehab
63 = Discharged to Long Term Care Hospital
64 = Discharged to Nursing Facility
65 = Discharged to Psychiatric Hospital
66 = Discharged to Critical Access Hospital

42. Revenue Code (Codes found in CMS UB-04 Manual) **Required**

- Use Revenue Codes 0100 through 0179 to report In-Facility Days.
- Use Revenue Code 0183 to report Therapeutic Leave Days.
- Use Revenue Code 0185 to report Hospital Leave Days.
- Use Revenue Code 0180 to report Non-Billable Leave Days.

43. Revenue Description **Situational**

For Assisted Living Facilities, the following descriptions may be used as appropriate:

- Days in ALF
- Hospital Leave Days
- Therapeutic Leave Days

44. Rates **Required**

Enter provider's usual and customary rate.

46. Units of Service **Required**

Enter the number of days corresponding to the Revenue Code(s) reported in 42. Days must be entered as whole numbers, not decimals or fractions.

Must reflect the number of paid calendar days

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

Multiply the number of days reported in 46 by the rate reported in 44.

54. Prior Payments - Payers **Situational**

Enter patient's share of cost amount (POS), if paid.

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

The unique identification number assigned to the provider submitting the claim.

58. Insured's Name **Required**

Enter Medicaid recipient's name.

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

Use Patient Relationship code 18 for all claims.

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

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

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

Required when type of bill frequency code (FL04) indicates this claim is a replacement claim or void due to a previously adjudicated claim. Enter the original claim number in this field.

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) code describing the principal/primary diagnosis.

For Assisted Living Facilities use the following:

ICD	Principal Diagnosis Code
ICD-9-CM	V719
ICD-10	Z049

ICD-9 should be entered for all admission dates prior to 10/01/2015.

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

Enter the 10-digit taxonomy code of the billing provider, as reported to Nebraska Medicaid.

81cc.b. ZIP code of the Billing Provider **Required**

Enter the nine-digit Zip Code (Zip+4) of the billing provider, as reported to Nebraska Medicaid.