CLAIMS RELATED INFORMATION

Reimbursement requires compliance with all Medicaid guidelines.

Claim Related Responsibilities

All providers are responsible for including the correct billing codes on a claim. If a licensed practical nurse (LPN) provides services, the provider must submit the appropriate LPN code for payment. Likewise, if a registered nurse (RN) delivers the service, the claim must identify the code associated with the appropriate service. Home health providers should perform a self-audit to identify claims paid incorrectly and report any overpayments to the fiscal intermediary (FI). All providers are responsible for assuring that their professional employees (i.e. RNs, LPNs, aides, etc.) are practicing within the limitations established by their licensing boards.

The home health agency (HHA) must provide the supporting documentation used to document medical necessity criteria (i.e. medical doctor's prescription, etc.) which must be met in order to receive home health services upon request.

Claim Type

HHAs can submit claims either by paper or electronically. Home health providers who choose to submit their claims on paper forms must use the Centers for Medicare and Medicaid Services (CMS) standard **UB-04** claim form.

The HHA must bill using its own Medicaid provider number and National Provider Identifier (NPI).

Diagnosis Codes to Support Medical Necessity

Providers must bill using the appropriate International Classification of Diseases, Tenth Edition, Clinical Modification, Tenth Revision (ICD-10-CM) diagnosis code(s), or its successor, that best describes the beneficiary's illness, injury or medical condition.

Billing Codes

The procedure codes and revenue codes to be used for billing covered home health services can be found in "Louisiana Medicaid Home Health Revenue and Procedure Codes" under the "Fee Schedules" link at www.lamedicaid.com.

Billing Instructions for Home Health Services

The UB-04 claim form (hard copy) or 837I electronic transaction is required when filing for Medicaid reimbursement of services. All information, handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.

As a reminder, the beneficiary's authorized healthcare provider's (AHP's) name and provider number is always required when submitting for reimbursement of services. Please see chart below for correct placement of this information on the UB-04 Claim Form and 837I electronic format.

UB-04 Claim Form	837I Electronic Format
Form Locator 76 – Attending Provider (Required) Enter the name or 7-digit Medicaid provider number of the AHP ordering the plan of care.	**Loop 2310A, REF02 segment OR Loop 2420A, REF02 segment** Enter the name or 7-digit Medicaid provider number of the AHP ordering the plan of care.

Billing Instructions for Extended Home Health Services Including Modifiers

Prior authorization (PA) must be obtained from the Prior Authorization Unit (PAU) for extended home health (EHH) services, and any modifiers. When billing for the approved number of hours providers should include the relevant modifier related to that procedure code.

For example, if four units are approved without a modifier and four units with the UJ modifier, these must be billed **individually** on a separate line of the claim form. Providers shall use the correct procedure code and modifier for each line item.

Description	HCPCS	Modifier Code(s)	Service Date	Units
Nurse Care in Home - LPN	S9214		12/15/2099	4
Nurse Care in Home - LPN	S9124	UJ	12/15/2099	4

Providers shall refer to Section 23.5 - Prior Authorization for the application and use of modifiers.

Billing Instructions for Multiple Same Day Visits

PA **must** be obtained from the PAU before any multiple same day visits are provided for beneficiaries under the age of 21 who are not receiving EHH. When billing for the multiple daily visits, the claim form should have each visit listed on a separate line with the correct procedure code and modifier codes to reflect the multiple day visits (see "Louisiana Medicaid Home Health Revenue and Procedure Codes" under the "Fee Schedules" link at www.lamedicaid.com).

Example:

Jane Doe needs a nurse to visit her three times a day, one (1) RN and two (2) LPNs. The beneficiary will need these services on December 15, 2099.

A PA-07 request is completed by the provider requesting approval for the two additional visits a day and submitted to the PAU. Documentation, including the AHP's orders and the plan of care (POC) signed by the AHP, is submitted to substantiate the medical necessity of the additional visits.

When the PA is approved, a PA number is assigned and included in the notice authorizing the additional daily visits.

The 9-digit PA number assigned by the PAU must be included in Form Locator 63 A of the UB-04 claim form or in the Prior Authorization Loop for Electronic Data Interchange (EDI) transmissions (see EDI Companion Guide for details).

A standard unit of service is 15 minutes. **Each unit** must be billed **individually** on a separate line of the claim form. Please be sure to use the correct procedure code and modifier (if applicable) for each line item. (See sample below).

Please refer to the Louisiana Medicaid Home Health Revenue and Procedure Codes document and fee schedule at www.lamedicaid.com for the current modifiers, Healthcare Common Procedure Coding System (HCPCS) and revenue codes.

Description	HCPCS	Modifier Code(s)	Service Date	Units
Skilled Nurse Visit - RN	G0299		12/15/2099	1
Skilled Nurse Visit - RN	G0300	U2	12/15/2099	1
Skilled Nurse Visit - RN	G0300	U3	12/15/2099	1

Only one PA number may be entered per UB-04 claim form. Use of an incorrect PA number will cause the claim to deny.

Billing Instructions for Overtime Modifier

A home health agency may also submit claims using the overtime (TU) modifier to identify hours for an EHH beneficiary that were paid as overtime to the nurse delivering the care. This modifier shall not require a prior authorization, but must be for hours already authorized for the beneficiary. When billing, this modifier may be used in addition to any other authorized modifiers (e.g., TG) for procedure codes S9123 and S9124, but shall be paid at 1.5 times the base rate of the procedure code.

The use of this modifier is subject to post payment review. The HHA should maintain all necessary documentation to support the use of this modifier. Non-compliance with written policy may result in recoupment and additional sanctions, as deemed appropriate by Louisiana Medicaid.

Billing Instructions for Rehabilitation Services

The Medicaid program provides coverage for physical therapy, speech therapy and occupational therapy through the Home Health program. These services require prior authorization.

The service codes used for billing as well as the corresponding procedure codes are listed in "Louisiana Medicaid Home Health Revenue and Procedure Code" under the "Fee Schedules" link at www.lamedicaid.com. Reimbursement will be made at a flat fee for service.

Cardiac and pulmonary/respiratory therapy are not covered under the Medicaid program. These services should not be prior authorized or billed using covered rehabilitation codes.

NOTE: HHAs are not to bill Medicaid for rehabilitation services rendered in nursing homes. Per 42 CFR 440.70(c), "A beneficiary's place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities..."

Wheelchair Seating Evaluation

When billing for a wheelchair seating evaluation, a paper claim **must** be submitted with a copy of the AHP's prescription attached to the claim, (8 ½ x 11 sheet), and the original prescription **must** be kept in the beneficiary's file.

Rehabilitation Services Rendered To Dual Eligible Beneficiaries

If a particular beneficiary is eligible for both Medicaid and Medicare services, the rehabilitation provider rendering services to the beneficiary must be willing to accept the Medicare assignment in order for Medicaid to make crossover payment on the claim.

Rehabilitation providers must bill for Medicare/Medicaid crossovers on the UB-04 claim form and file the claim with Medicare first, ensuring that the beneficiary's Medicaid identification number has been entered on the claim form. Once Medicare has processed the Medicare portion of the claim, the claim payment information must be sent to the PAU for processing.

Providers should receive Medicaid payment within six weeks after receiving payment from Medicare. If payment is not received from Medicaid, providers should submit the UB-04 claim form, along with the Medicare Explanation of Benefits (EOB), to the FI for processing.

Billing for Supplies through the Durable Medical Equipment Program

Foley and indwelling catheters may not be billed through the Durable Medical Equipment (DME) program.

Reimbursement for supplies that are considered "routine supplies" are included as part of the home health visit rate and may not be billed to Medicaid nor to the beneficiary. The appropriate procedure code should be used for each supply requested.

Supplies included in the reimbursement for a Home Health Visit

Routine supplies, as determined by Medicaid, that are not reimbursed through the DME program are considered included in the home health visit rate and will not be separately reimbursed.