CLAIMS RELATED INFORMATION

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in CommunityCARE programs.

Claim Related Responsibilities

All providers are responsible for filing the correct billing codes on a claim. If an LPN provided 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 in assuring that your professional employees (ex. RNs, LPNs, Aides, etc.) are only practicing within the limitations established by their licensing boards.

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

Claim Type

Home Health Agencies can submit claims by paper or electronic formats. 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, Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis code(s) that best describes the recipient's illness, injury or medical condition.

Billing Codes

The procedure codes and revenue codes to be used for billing covered HHA services can be found in appendix C.

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, when submitting to Medicaid for reimbursement of services the recipient's **attending physician's** name and/or provider number is always required. Should the recipient have a CommunityCARE PCP, the **referral authorization number** is also required. Please see chart below for correct placement of this information on the UB-04 Claim Form and 837I Electronic Format.

NOTE: Providers must complete both fields if the recipient being treated is in the CommunityCARE Program even if the attending physician and the CommunityCARE PCP are the same.

UB-04 Claim Form	837I Electronic Format
Form Locator 82 – Attending Physician (Required) Enter the name or 7 digit Medicaid provider number of the physician 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 physician ordering the plan of care.
Form Locator 83A – Other Physician (Situational) Enter the referral authorization number from the CommunityCARE Referral Form if the claim is for a CommunityCARE recipient.	**Loop 2310C, REF02 segment** **OR** **Loop 2420C, REF02 segment** Enter the referral authorization number from the CommunityCARE Referral Form if the claim is for a CommunityCARE recipient.

Billing Instructions for Multiple Same Day Visits

Prior authorization **must** be obtained from the PAU before any multiple same day visits are provided. 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 Appendix C).

Example:

Jane Doe needs a nurse to visit her three times a day, one registered nurse and two licensed practical nurses. She 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 physician's orders and the Plan of Care (POC) signed by the physician, is submitted to substantiate the medical necessity of the additional visits.

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

The 9-digit prior authorization 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 EDI transmissions (see EDI Companion Guide for details).

Each visit 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)

Description	HCPCS	Modifier Code(s)	Service Date	Units	Total Charges
Skilled Nursing Visit	G0154	TD	12/15/2099	1	$65.22
Skilled Nursing Visit	G0154	TE U2	12/15/2099	1	$52.17
Skilled Nursing Visit	G0154	TE U3	12/15/2099	1	$52.17

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 Rehabilitation Services

Louisiana Medicaid provides coverage for speech therapy and occupational therapy, as well as physical therapy, through the Home Health Program. These services require prior authorization.

The service codes used for billing as well as the corresponding procedure codes and fees are listed in Appendix C. Reimbursement will be made at a flat fee for service.

NOTE: Cardiac and Pulmonary/Respiratory therapy are not covered under Louisiana Medicaid. These services should not be prior authorized or billed using covered rehabilitation codes.

NOTE: Home Health agencies are not to bill Medicaid for rehabilitation in nursing homes. As per the Code of Federal Regulations, "A recipient's place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded."

Wheelchair Seating Evaluation

When billing for a wheelchair seating evaluation, a paper claim **must** be submitted with a copy of the MD script attached to the claim, (8 ½ X 11 sheet), and the original script **must** be kept in the recipients' file. Refer to appendix C for procedure codes.

Rehabilitation Services Rendered To Dual Eligible Recipients

If a particular recipient is eligible for both Medicaid and Medicare services, the rehabilitation services provider rendering services to the recipient must be willing to accept 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 recipient'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 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 or to the recipient. The appropriate procedure code should be used for each supply requested (see appendix C).

Supplies included in the reimbursement for a Home Health Visit

Routine supplies as determined by Medicaid home health that are not reimbursed through the Medicaid Durable Medical Equipment and Supplies Program are considered included in the visit rate and will not be separately reimbursed.