CLAIMS RELATED INFORMATION

Reimbursement requires compliance with all Medicaid requirements. Hospice providers bill for room and board using the standard 837 Institutional (837I) electronic claim transaction or the hardcopy UB-04 Form, regardless of the date of service. All supplemental billing must also be submitted electronically using the 837I format or on the UB-04 hard copy claim form. The 837I is the preferred method of claim submission.

Diagnosis Codes

Bill using the appropriate ICD-9-CM diagnosis codes that supports medical necessity.

NOTE: Listings of Louisiana Medicaid hospice approved diagnosis codes can be found in Appendix C.

Revenue Codes

Bill for hospice services provided according to the level of care and location of the recipient for each day of the hospice election period.

Frequency of Billing

The UB-04 should be submitted no more frequently than once each month; after the month within which services were provided. Providers do not have to split a claim for a month's dates of services around the recipient's election period dates. However, a claim cannot span more than two election periods. The provider should split bills if they span the effective date of the annual increase in the payment rates for hospice care services.

Claims Submission for Recipients Residing In the Home

Hospice providers only bill for direct hospice services when a recipient resides in the home, unless the recipient is dual eligible with Medicare Part A, then no bill should be submitted to Medicaid since Medicare Part A reimburses hospice services at 100 percent.

Claims Submissions for Recipients Residing In a Long Term Care Facility

Hospice providers bill for both direct **hospice** services and **room and board** when a recipient resides in a Nursing Facility, **unless** the recipient is dual eligible with Medicare Part A, then Hospice providers will bill only for room and board. Because Medicare Part A reimburses hospice services at 100 percent, no bill for direct hospice services or room and board in a skilled nursing facility should be submitted to Medicaid.

The room and board rate of reimbursement is 95% percent of the per diem rate that would have been paid to the facility for that recipient in that facility under the State Plan, except that any Patient Liability Income (PLI) determined by the Bureau will be deducted from the payment amount. It is the responsibility of the nursing facility or Intermediate Care Facilities for the Intellectually Disabled (ICF-DD) to collect the recipient's PLI.

Hospice providers may only bill Medicaid once per calendar month for nursing facility or ICF-DD room and board.

Medicaid Only: Providers should bill for routine or continuous home care and bill the rate to cover room and board as appropriate. The parish office will advise the resident and nursing facility or ICF-DD of the resident's patient liability income (PLI). Medicaid will deduct the resident's PLI from the amount to be reimbursed to the hospice. The hospice is to pay the facility according to the contract agreement subject to adjusted claims the nursing facility may encounter as a result of case mix methodology.

Medicaid and Medicare (dually eligible): Providers should bill for the room and board rate for each day the resident is in the facility. Providers should bill Medicare for routine or continuous home care, as appropriate. The hospice is to pay the facility according to the contract agreement subject to adjusted claims the nursing facility may encounter as a result of the case mix methodology.

NOTE: General inpatient care and room and board **cannot** be reimbursed for the same recipient for the same covered day of service.

Claims Submissions for Schedule (Room and Board ONLY)

Claims for room and board are processed according to a predetermined schedule set by DHH and is updated every calendar year. This schedule includes deadlines for initial monthly claim submissions as well as for monthly supplemental claim submissions.

NOTE: Providers who bill hardcopy claims should continue to submit the initial monthly UB-04 forms in one package.

Levels of Care Billing

Payment rates are determined at one of four levels for each day of a recipient's hospice care. Providers should use the following chart to determine the appropriate level for billing.

Revenue Code	Units of Service	Level of Care	Required Documentation
651	24-Hours (1 day)	**Routine Home Care** The routine home care rate is paid for each day the recipient is under the care of the hospice and not receiving one of the other categories of care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. It is also paid when the recipient is receiving hospital care for a condition **unrelated** to the terminal condition. This rate is also paid in the following situations: (1) recipient is in a hospital that is not contracted with the hospice; (2) recipient is in a hospital for care unrelated to the terminal condition; (3) recipient is receiving outpatient services in the hospital; or (4) for the day of discharge from general inpatient care or respite level of care.	The hospice must develop and maintain a plan of care (POC) for the recipient. The recipient's clinical record should include any updates to the POC and changes to the recipient's condition between the updates. The recipient's clinical record should include all disciplines' daily/weekly/monthly progress notes that record the type and frequency of the services provided to the recipient.

Revenue Code	Units of Service	Level of Care	Required Documentation
652	1 Hour	**Continuous Home Care** A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. This care need not be continuous, i.e., four hours could be provided in the morning and another four hours provided in the evening of that day. Homemaker and aide services may also be provided to supplement the nursing care. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.	**Documentation must:** Clearly document reason for continuous care. List the dates of service that the recipient was under continuous home care. Record hour by hour and day by day what services were provided, the recipient's condition, and the type of personnel providing the continuous care.
655	1 Day	**Inpatient Respite Care** The payment for respite care may be made for a maximum of five consecutive days in an election period at a time including the date of admission but not counting the date of discharge alive. Payment for the sixth and any subsequent days is to be made at the Routine Home Care Rate.	**Documentation must:** Clearly indicate the facility in which the recipient is receiving the respite level of care, the dates the recipient was at respite level of care, and why the respite was necessary.

Revenue Code	Units of Service	Level of Care	Required Documentation
656	1 Day	**General Inpatient Care** For the date of admission to the contracted inpatient facility, the general inpatient rate is to be paid. For the day of discharge from the contracted inpatient unit, the appropriate routine home care rate is to be paid unless the recipient dies as an inpatient. Upon death, the general inpatient rate is to be paid for the discharge date for the recipient admitted to the contracted facility. The provider should **bill revenue code 656 for recipients admitted to a contracted facility.** **The hospice may not bill the general inpatient rate for days the recipient is in a non-contracted facility or in a facility for a reason unrelated to the terminal condition or an inpatient facility where the facility is considered the recipient's temporary or permanent residence/home. The hospice bills routine home care rate for these days.**	The name of the facility in which the recipient is receiving the general inpatient level of care; The dates the recipient was at the general inpatient level of care; A clear explanation of the reason why the admission was necessary; The recipient's condition during the inpatient stay; and The physician's discharge summary and any hospice interdisciplinary notes during the recipient's inpatient stay. NOTE: General inpatient care days are subject to limitations. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. Payment for this care is limited to 5 days in an election period. Once the symptoms are under control, routine home care must be billed.

Revenue Code	Units of Service	Level of Care	Required Documentation
657	1 day	**Physician Services** For use when physician professional services are being provided to hospice recipients; and the hospice is responsible for reimbursing the physician. The physician can be an employee of the hospice, a volunteer, or a consultant.	Document all recipient encounters.

Third Party Liability

Medicaid, by law, is intended to be the payer of last resort. Therefore, other available third-party resources, including private insurance, must be used before Medicaid pays for the care of a Medicaid recipient.

If probable third-party liability (TPL) is established at the time the claim is filed, Medicaid will deny the claim and return it to the provider for determination of third-party liability for most Medicaid services. In these cases, the Bureau will then pay the balance of the claim to the extent that payment is allowed under Medicaid's fee schedule after the third party's payment. EPSDT diagnostic and screening services are exempt from this requirement. For these services, Medicaid will pay the claim up to the maximum allowable amount. However, these exceptions do not include treatment or therapy that must be billed to the recipient's third-party carrier if applicable) prior to billing Medicaid. When Medicaid is billed, the claim must be filed hardcopy with the third-party carrier's Explanation of Benefits (EOB) attached to the claim form.

Exception: The only time Medicaid is considered primary is when the recipient has health coverage through Indian Health Services. In these cases, claims should be billed to Medicaid first, then to Indian Health Services.

Timely Filing Guidelines

To be reimbursed for services rendered, all providers must comply with the filing limits set by the Medicaid Program. Refer to Chapter 1 of the Louisiana Medicaid provider manual, General Information and Administration. The manual can be accessed on the internet at www.lamedicaid.com.