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.

Medicaid Requirements for Enrolling Ordering, Prescribing and Referring Providers

The Affordable Care Act (ACA) requires physicians or other practitioners who order, prescribe, or refer items or services to Medicaid beneficiaries to enroll in the Medicaid Program, even when they do not submit claims to Medicaid. ACA requirements are designed to ensure that items or services for Medicaid beneficiaries originate from appropriately licensed providers who have not been excluded from Medicare or Medicaid.

Individuals who order, prescribe, or refer items or services for Medicaid beneficiaries, but choose not to submit claims to Medicaid, are referred to throughout this notice as "OPR providers."

Professional and Institutional Billing Providers should begin notifying any individuals who you report on fee-for-service claims as an ordering, prescribing or referring provider that they must enroll with Louisiana Medicaid.

OPR providers must understand the implications of failing to enroll in Medicaid. If you are an OPR provider, then the individuals and facilities who bill services for Medicaid beneficiaries based on your order, prescription, or referral will not be paid for those items or services unless you enroll in Medicaid. Timely filing claim requirements may be impacted while waiting for providers to be enrolled; therefore, applications should be submitted as quickly as possible.

Effective with claims using dates of service on or after September 1, 2016, the Louisiana Medicaid Program will deny fee-for-service claims that use referring providers who are not enrolled as of the date of service. Providers should monitor the Louisiana Medicaid website for future information specific to ordering providers.

Louisiana Medicaid has established edits for issues with prescribing providers.

Enrollment

Practitioners currently enrolled as participating providers in fee-for-service Medicaid Program are not required to enroll separately as an OPR provider.

Diagnosis Codes

All billers should use the correct diagnosis codes (ICD-10-CM or its successor) that supports medical necessity and are appropriate for use with hospice related conditions.

Revenue Codes

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

Frequency of Billing

The UB-04 form should be submitted each month after the month for which services were provided. Providers do not have to split a claim for a month's dates of service around the beneficiary'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 Beneficiaries Residing In the Home

Hospice providers only bill for direct hospice services when a beneficiary resides in the home. If the beneficiary is dual eligible with Medicare Part A, a bill should not be submitted to Medicaid because Medicare Part A reimburses hospice services at 100 percent.

Claims Submissions for Beneficiaries Residing In a Long Term Care Facility

Hospice providers' bill for both direct hospice services and room and board when a beneficiary resides in a Nursing Facility unless the beneficiary is dual eligible with Medicare Part A. If the beneficiary is dual eligible with Medicare Part A, then Hospice providers 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 beneficiary in that facility under the Medicaid State Plan, except that any patient liability income (PLI) determined by the Bureau of Health Services Financing will be

deducted from the payment amount. It is the responsibility of the nursing facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) to collect the beneficiary's PLI.

Hospice providers may only bill Medicaid once per calendar month for nursing facility or ICF-IID 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 Medicaid parish office will advise the resident and nursing facility or ICF-IID 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 provider 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 (dual 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 provider 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 beneficiary 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 the Louisiana Department of Health (LDH) and is updated every calendar year. This schedule includes deadlines for initial monthly claim submissions as well as deadlines 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 the four levels for each day of a beneficiary'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 beneficiary 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 beneficiary is receiving hospital care for a condition **unrelated** to the terminal condition. This rate is also paid in the following situations if the beneficiary is: 1. In a hospital that is not contracted with the hospice; 2. In a hospital for care unrelated to the terminal condition; 3. 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 beneficiary. The beneficiary's clinical record should include any updates to the POC and changes to the beneficiary's condition between the updates. The beneficiary's clinical record should include all disciplines' progress notes (daily/weekly/monthly) that record the type and frequency of the services provided to the beneficiary.
659	1unit=15 minutes	**Service Intensity Add-On Rate (SIA)** SIA will be reimbursed only when billed in conjunction with the Routine Home Care code. Services must be rendered by a registered nurse or a social worker only. Bill codes G0299 (registered nurse) or G0155 (social worker) for each day a visit is made within the last seven days of a person's life. Claims must be submitted in hardcopy with documentation and progress notes justifying the intensity and number of visits. Payment will be reimbursed in 15 minute increments (one unit). The maximum total billed per day cannot exceed four hours.	The date of service must have been previously submitted to Medicaid and/or the appropriate health plan and is already on file before payment can be made on the SIA rate.

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 beneficiary was under continuous home care. Record hour by hour and day by day what services were provided, the beneficiary'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 day is to be made at the routine home care rate.	**Documentation must:** Clearly indicate the facility in which the beneficiary is receiving the respite level of care, the dates that the beneficiary was at respite level of care, and why the respite care was necessary. **NOTE:** The total number of days allowed is subject to the inpatient care cap. See provider responsibilities for more information.

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 beneficiary dies as an inpatient. Upon death, the general inpatient rate is to be paid for the discharge date for the beneficiary admitted to the contracted facility. The provider should **bill revenue code 656 for beneficiaries admitted to a contracted facility.** **The hospice may not bill the general inpatient rate for days that the beneficiary is in a non-contracted facility or in a facility for a reason unrelated to the terminal condition or in an inpatient facility where the facility is considered the beneficiary's temporary or permanent residence/home. The hospice bills routine home care rate for these days.**	**Documentation must include:** The name of the facility in which the beneficiary is receiving the general inpatient level of care; The dates the beneficiary was at the general inpatient level of care; A clear explanation of the reason why the admission was necessary; The beneficiary's condition during the inpatient stay; and The physician's discharge summary and any hospice interdisciplinary notes during the beneficiary'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. Once the symptoms are under control, routine home care must be billed. The total number of days allowed is subject to the inpatient care cap. See provider responsibilities for more information.
657	1 day	**Physician Services** For use when physician professional services are being provided to hospice beneficiaries; 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 beneficiary 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 beneficiary.

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 then pays the balance of the claim to the extent that payment is allowed under Medicaid's fee schedule after the third party's payment. Early and periodic screening, diagnosis, and treatment (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 beneficiary's third-party carrier (if applicable) prior to billing Medicaid. When Medicaid is billed, hard copy of the claim must be filed with the third-party carrier's Explanation of Benefits (EOB) attached to the claim form.

For beneficiaries with private insurance, hospice providers should still submit requests for hospice services timely to the hospice Prior Authorization Unit (PAU) in order for the appropriate reviews and future accurate reimbursement to take place.

Exception: The only time Medicaid is considered as primary is when the beneficiary 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.