REIMBURSEMENT

Providers must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier. (Refer to Appendix E in this manual chapter for information about procedure code, unit of service and current reimbursement rate).

Reimbursement must not be made for services provided prior to approval of the plan of care (POC) and release of prior authorization (PA) for these services.

Medicaid is the payer of last resort in accordance with federal regulation 42 CFR-433.139. Failure by the provider to exhaust all third party payer sources may subject the enrolled provider to recoupment of funds previously paid by Medicaid. Third parties include, but are not limited to, the following:

1. Private health insurance;
2. Casualty insurance;
3. Worker's compensation;
4. Estates;
5. Trusts;
6. Tort proceeds; and
7. Medicare.

The claim submission date cannot precede the date the service was rendered.

Long Term – Personal Care Services (LT-PCS) providers are reimbursed at a per quarter-hour rate for services under a prospective payment system (PPS) that recognizes and reflects the cost of direct care services provided.

Release of PA for LT-PCS is contingent on post authorization. Post authorization occurs through the Electronic Visit Verification (EVV) system. EVV is mandatory for LT-PCS. The EVV system requires use of the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by the Bureau of Health Services Financing (BHSF) and the Office of Aging and Adult Services (OAAS). The system is to be used to electronically "check in" and "check out" when the LT-PCS worker begins and when they end service delivery to a participant.

While there may be some circumstances that require manual edits by the provider's designee, these should only be occasional. In the event that there is a billing overlap, the provider that uses the EVV system correctly (i.e. data has not been manually added or edited) will have priority for payment.

Providers who are approved to provide services to more than one beneficiary under shared LT-PCS (through the Adult Day Health Care (ADHC) Waiver), must bill separately for each beneficiary based on his/her POC. Each beneficiary must be present to receive the shared service in order for the provider to bill for the service.

Span Date Billing

Claims cannot be span-dated for a specified time-period. Each line on the claim form must represent billing for a single date of service.

See Section 30.5 – *Service Authorization Process* of this manual chapter for details about when claims for LT-PCS may be filed.