Amerigroup RealSolutions in healthcare

Provider update

Amerigroup Community Care — hospice tips

Summary: Amerigroup is pleased to provide our hospice provider community with a hospice tip sheet. This document is designed to give a high-level overview, including CMS, TennCare and Amerigroup guidelines for credentialing, authorizations, claims submissions, 2016 CMS routine care changes and service intensity add-on (SIA) payments.

Credentialing requirements

- A full and complete credentialing application must be included with all required forms.
- For providers that provide palliative or physician care, please attach a completed provider roster that includes all required demographic elements for loading into our claims adjudication system.
- Recredentialing is required every three years for each hospice provider.
- Every hospice provider should be fully registered with TennCare, have a valid Medicaid ID and an active *Disclosure of Ownership* on file to adhere to the TennCare policy:
    - Link to TennCare: www.tn.gov/tenncare/topic/provider-registration
    - Link to the provider manual: https://providers.amerigroup.com/TN > Manuals & QRCs > Medicaid Provider Manual

Authorization requirements

- No medical necessity review is required or conducted for any hospice services.
- Authorizations are not required for dual members (members enrolled in both Medicare and Medicaid) for room and board services.
    - Notifications are required for dual members for room and board services.
- Authorizations are required for dual members for hospice services.
- Authorizations are required for nondual members for room and board and/or hospice services.
- When completing the *Precertification Request* form, please include all member and provider information as well as the *Provider Certification* or *Plan of Care* (signed by the medical doctor) that has the date of service or certification period (https://providers.amerigroup.com/TN).
- When requesting authorizations, please make sure they are for appropriate Q series procedure codes.
    - Authorizations must be requested for the code submitted or the claims will be denied. This would necessitate a corrected claims submission in order to process within timely filing guidelines.

Billing room and board claims

- Revenue code 0658 and procedure codes Q5003 (level 1) or Q5004 (level 2) should be used.
- The use of T codes will cause the claim to deny as a billing error.
- The nursing facility name and facility level ID must be included in box 80 of the *UB-04* claim form.
- Patient liability information should be in box 39, 40 or 41 with value code 23 and the patient liability amount. If there is no patient liability, please enter $0.
- If patient liability is left blank, the claim will deny as a billing error.
- Provider should bill for date of death.

- Example of room and board calculation:

Level 1 nursing facility rate	$175
Hospice reimbursement 95% of above rate	$166.25
Q5003 room and board units	x 31
Total	$5,153.75
Member liability amount	- $1,000
Total claim pay amount	$4,153.75

2016 routine care and SIA payments

- Routine care (revenue code 0651 with applicable HCPCS Q codes) will be reimbursed depending on the number of days the member is in hospice. The payment will be reduced beginning with day 61. These calculations are subject to the normal wage index.
- SIA payment for hospice services will include revenue code 0551 with HCPCS code G0299 (RN) or revenue code 0561 with HCPCS code G0155. Reimbursement will have a max of four hours (in 15-minute intervals) or 16 units per day combined for both disciplines. These services will occur during the last seven days of life.
- Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll within 60 days will continue with the current date/payment calculations.
- Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll outside of 60 days will restart routine care eligibility and day one for pricing.

Quality and nonquality data criteria

- Amerigroup reimbursement mirrors the federal Medicare policy.
- Annual reimbursement rates for CMS Medicaid hospice are effective October 1 of each fiscal year.
- Reimbursement is based on the location of the hospice provider.
- CMS will provide a listing of facilities that meet the quality data criteria for each fiscal year starting October 1, 2016.
- Amerigroup will validate each fiscal year provider report and update rates accordingly.

What if I need assistance?

If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.