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Provider update

Hospice tips

Summary: Amerigroup Community Care is pleased to provide our hospice provider community with a hospice tip sheet. This document is designed to give a high-level overview and includes CMS, TennCare and Amerigroup guidelines for credentialing, authorizations, claims submissions, 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 who 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: https://www.tn.gov/tenncare/providers.html
    - Link to the provider manual: https://providers.amerigroup.com/TN > Manuals & QRCs > Medicaid Provider Manual

Authorization requirements:

- Hospice (Q codes) authorizations are not required for all members (members enrolled in both Medicare and Medicaid) as of July 1, 2017.
- No medical necessity review is required or conducted for any hospice services.
- **Authorization is required for SIA procedure codes G0299, G0300 and G0155:**
    - **SIAs are postauthorization requests and can be requested up to two weeks after a member's death.**
    - When completing the *Precertification Request* form, please include all member and provider information, as well as the member's date of death, dates of service for SIA, number of visits/hours and procedure code(s) (https://providers.amerigroup.com/TN).
    - Fax the request to 1-866-495-5789.

Billing room and board claims:

- Effective July 1, 2018, there are no longer distinct Level 1 and Level 2 nursing facility rates in the State of Tennessee.
- Nursing facility reimbursement rate changes were implemented August 1, 2018, but were in effect as of July 1, 2018.
- The new blended rate will be loaded to the Nursing Facility Level 1 Medicaid ID.
- 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.
- Hospices must report the NPI of any nursing facility where the patient is receiving hospice services, regardless of the level of care provided when the site of service is not the billing hospice.
- As of July 1, 2018, the billing hospice provider must now obtain the NPI for the facility where the patient is receiving care and report the facility's name, address and NPI in box 80 of the *UB-04* claim form. If any of the three items are missing in box 80, the claim will deny as a billing error.
    - Box 80 contains four lines with a 19-character limit on line 1 and a 24-character limit for each lines 2-4.

- 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.
- Providers should bill for date of death.

Example of room and board calculation:	
Blended 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. Per CMS, the state period cannot span accounting years.
- 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.

Palliative care and physician charges:

- Services should be billed on a *CMS-1500* (professional) claim form.
- For palliative care, the claim should include the appropriate required data including CPT codes, practitioner in box 24j and the hospice billing facility in box 33.
- There are no benefit or lifetime maximum restrictions for palliative care.

What if I need assistance?

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