Fee-for-Service
Home Health, Hospice, and Long-Term Care
Agenda

- Reference resources
- Home health
- Hospice
- Long-term care
- Reminder
- Helpful tools
- Questions
Reference resources
COREMMIS AND NEW PROVIDER HEALTHCARE PORTAL ARE LIVE!

The Indiana Health Coverage Programs (IHCP) has implemented its new information processing system, CoreMMIS, as well as the new provider interface called the Provider Healthcare Portal (Portal). Find important information about the new system on the Indiana CoreMMIS and Provider Healthcare Portal web pages, and watch for IHCP bulletins to learn about post-implementation updates.

NEWS AND ANNOUNCEMENTS

income limits now calculating correctly for presumptive eligibility applications. 27/11/2012 - The Indiana Health Coverage Programs (IHCP) previously identified that the federal poverty level (FPL) income limits for its programs were not calculated correctly for certain presumptive eligibility applications. This issue has now been resolved.
PROVIDER REFERENCE MATERIALS

Don't miss important information! Sign up to receive email alerts when new information is posted to the IHCP website. Click here to sign up now!

Providers may access or download copies of documents from this website. NOTE: If you have trouble opening linked PDF files, view the PDF Help page.

MEDICAL POLICY MANUAL

<table>
<thead>
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<th>Name</th>
<th>Effective Date</th>
<th>Version</th>
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<tbody>
<tr>
<td>Medical Policy Manual</td>
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IHCP COMPANION GUIDES

For information about electronic transactions, HIPAA version 5010, see the IHCP Companion Guides page.
Provider reference materials

- Provider modules are available at indianamedicaid.com – see *Provider Reference Materials* quick link.

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<thead>
<tr>
<th>Service</th>
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<td>Hospice Services</td>
<td>April 1, 2016</td>
<td>1.2</td>
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<tr>
<td>Hospital Assessment Fee</td>
<td>April 1, 2016</td>
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<td>Injections, Vaccines, and Other Physician-Administered Drugs</td>
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<td>Inpatient Hospital Services</td>
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<tr>
<td>Long-Term Care</td>
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PROVIDER-SPECIFIC INFORMATION

Are you a Medicaid pharmacy provider? Do you provide hospice or long-term care services? The Indiana Health Coverage Programs (IHCP) offers information to help specialized providers better serve their Indiana Medicaid members, including extensive information about IHCP pharmacy and long-term care services, as well as managed care entities (MCEs). Select a topic from the menu on the left or from the following links.

- Managed Care
- Hospice
- Long Term Care
- Pharmacy
Home health
Occurrence code is 73:

- If the dates of service billed are not consecutive, enter occurrence code and the date for each date of service.
  - Member is seen on the 1st, 3rd, and 5th – each date must be listed individually with the occurrence code.
- If the dates of service are consecutive, enter occurrence code and the occurrence span dates.
  - Member is seen on the 1st, 2nd, and 3rd – list date span (1st through 3rd) with the occurrence code.

For each encounter at home, providers can report only one overhead encounter per member per day.*

- In a multimember situation (for example, husband and wife both treated during same encounter), only one overhead is allowed.

*Example: RN visits in the morning, home health aide visits in the afternoon – only one overhead is billed on the claim.
Enter individual service dates if the dates are **nonconsecutive**.

### Home health

**Overhead – Provider Healthcare Portal**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Occurrence Code</th>
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Enter span-of-service dates if all dates billed **are consecutive**.

### Occurrence Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>73</td>
<td>07/10/2017</td>
<td>07/15/2017</td>
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</table>
Occurrence code 73 and nonconsecutive dates.

Occurrence code 73 and consecutive date span.

Occurrence code fields on paper are limited. Occurrence code fields on the Portal are unlimited.
Home health
**Bypass prior authorization**

Services *within 30 days of hospital discharge* with physician order for home health service bypass PA.

**Physician order must be in writing prior to discharge from the hospital.**

- Enter occurrence code 42 and the date of inpatient discharge on each claim to bypass PA.
  - RN, LPN, or home health aide not to exceed 120 units
  - Any combination of therapy services not to exceed 30 units in 30 calendar days

If services will exceed 30 days, or exhaust units, a prior authorization is required.
Can a member have home health and hospice at the same time?

- Yes – in specific circumstances when:
  - Diagnosis code for the terminal and the nonterminal illness are not related.
  - Thorough explanation of the medical necessity is in the PA request.

The hospice provider must submit the hospice plan of care and the home health plan of care to the IHCP fee-for-service prior authorization vendor, Cooperative Managed Care Services, to ensure a comprehensive review.
For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, bill the appropriate managed care entity (MCE).

indianamedicaid.com > Contact Us
- Contact information for the MCEs
- Provider field consultants for the MCEs
  - Anthem
  - CareSource
  - MDwise
  - MHS
Hospice
To be eligible for program services, IHCP members must:

- Have a prognosis of six months or less to live
- Must elect hospice services

Available hospice palliative care needs include, but are not limited to:

- Physical
- Psychological
- Social
- Spiritual

Hospice providers can provide hospice care to an IHCP member:

- In an inpatient setting
- In a nursing facility setting
- In the member’s home
According to 42 USC 1395d(d)(2) and 405 IAC 5-34-6(b), election to the hospice benefit requires the member to waive the following:

• Other forms of healthcare for treatment of the terminal illness for which hospice care was elected or for treatment of a condition related to the terminal illness (exception for members 20 years and younger)

• Services provided by another provider equivalent to the care provided by the elected hospice provider

• Hospice services other than those provided by the elected hospice provider or its contractors
Hospice

**Election for members 20 years or younger**

- Not required to waive other forms of healthcare for treatment of the terminal illness
- Concurrent hospice care and curative care benefits are available.
  - Curative care services are covered separately by the IHCP.

Hospice plan of care and a curative plan of care must both be submitted for PA review.

- Palliative treatment and management of terminal condition are supervised by the hospice provider.
Hospice Election

- Member must elect hospice services by completing a Medicaid Hospice Election State Form 48737 (R2/1-12).

- Medicaid Hospice Plan of Care for Curative Care – Members 20 Years and Younger form is available on the Forms page at indianamedicaid.com.

Form can be downloaded from the Forms page at indianamedicaid.com.
Hospice

Service intensity add-ons (SIA)

The service intensity add-on (SIA) payment is in addition to the routine home care per diem rate.

- Payment is made for services provided by an RN or social worker during the last seven days of a member’s life.

SIA is billed:

- With revenue code 551 for RN service intensity
- With revenue code 561 for social worker service intensity
- As detail line items on the claim
- With routine home hospice care revenue codes 651 or 653 on the same claim and same date of service
  - Watch for updates on revenue codes 65X.
- With discharge status codes 20, 40, 41, or 42 – required
- With occurrence code 55 and the date of death
Hospice

Aid categories not eligible for hospice benefit

• 590 Program
• Children’s Special Health Care Services (CSHCS)
• Aid to Residents in County Homes (ARCH)
• Qualified Medicare Beneficiaries Only (QMB Only)
• Specified Low Income Medicare Beneficiaries (SLMB-Only)
• Emergency Services Only (Package E)
• Limited benefits to pregnant women under Presumptive Eligibility for Pregnant Women (PEPW)
• Family Planning Eligibility Program
Hospice providers must identify the HIP member’s managed care entity (MCE).

- Prior authorization and claims payment must be directed to the HIP member’s MCE.
- A hospice provider must ensure that it is a HIP-enrolled provider with the HIP member’s MCE.
- Specific information about HIP and the managed care plans are available on the Healthy Indiana Plan page at indianamedicaid.com.
Hospice
Hoosier Care Connect – Current guidelines

Members receiving inpatient services remain enrolled with their managed care entity (MCE) with no change to their in-home hospice status under these conditions:

- Short-term, temporary, inpatient stays of up to five days per occurrence for respite care, pain control, and symptom management in any inpatient facility, including hospitals and nursing facilities
- General inpatient (GIP) hospital stays for treatment of symptoms unrelated to the terminal illness
- Nursing facility stays not to exceed 30 days

If the member is admitted to a nursing facility for more than 30 days, the member must be disenrolled from Hoosier Care Connect and enrolled in Traditional Medicaid.
Hospice
*Hoosier Healthwise*

- In-home and institutional hospice care are not covered benefits for Hoosier Healthwise members.
- Members must be disenrolled from managed care.
For members to be disenrolled from managed care:

- Fax member enrollment information to the IHCP PA contractor, CMCS.
- CMCS hospice analysts contact Maximus the same day.
- The hospice provider may start billing fee-for-service the day after the member is disenrolled from managed care.
  - The member’s eligibility will show Full Medicaid (FFS)

It is imperative that hospice providers indicate "Hospice Member Disenrollment from Managed Care” in the subject line of the fax.
Hospice
Effective January 1, 2019

*All* covered hospice benefits for Hoosier Care Connect will be the responsibility of the enrolling MCE.

- Members assigned to MHS or Anthem Hoosier Care Connect **will** remain enrolled with their managed care entity through the duration of the hospice period.
- Hoosier Healthwise members will continue to be transitioned to fee-for-service.

Refer to *BT201809* for additional information.
Long-term care
Long-term care

Nursing facility (NF) services are available to members who meet the threshold of nursing care needs required for admission to, or continued stay in, an IHCP-certified facility:

• Preadmission screening (PAS) for long-term care services is required for placement in an NF or preadmission screening resident review (PASRR) for continued stay.
• To access the required documents, visit the FSSA website.

An approved **Nursing Facility Level of Care** is required for IHCP reimbursement.
Long-term care
Revenue codes

Room and board is billed as follows:

• 110 – Room and board private
• 120 – Room and board semiprivate (two beds)

Bed-hold days are not reimbursed but should be reported:

• 180 – Bed-hold days
• 183 – Therapeutic bed-hold days
• 185 – Hospital bed-hold days
Long-term care

Discharge status codes

• The patient status code on the claim form is used to close the member’s level of care (LOC).
• This process eliminates the need to submit written discharge information to the FSSA.
• Using incorrect status codes:
  – Can result in overpayments, which result in recoupment
  – Prevents members from receiving services, such as home health services and pharmacy prescriptions, after discharge from the NF facility
Long-term care and hospice

Long-term care facility responsibility:
• Have an approved PAS, with a Medicaid effective date
  – Required for IHCP reimbursement
    ❖ NF does not bill for room and board.

Hospice responsibility:
• Submit claims with the appropriate revenue code indicating member is in an NF facility:
  – Bill type 822 and for hospice revenue codes 653, 654, 659, 183, and 185
  – Retro-rates are automatically mass adjusted:
    ❖ Retro-rate mass adjustment ICNs begin with “55.”
• Submit claims with the appropriate discharge status code for hospice services.
Long-term care is not a covered benefit under managed care programs. Members needing long-term care services must be transitioned from managed care to fee-for-service.

Hoosier Care Connect and Hoosier Healthwise members can obtain nursing facility coverage for short-term stays of 30 consecutive days or less.

- The MCEs notify the FSSA of any member requiring a stay longer than 30 days.
- MCEs can request a member be disenrolled from managed care.

Healthy Indiana Plan

- Covers up to 100 skilled nursing facility days per year.
- No coverage for custodial care or room and board.

Hoosier Healthwise Package C members do not have coverage for nursing facility care.
Long-term care
Frequently asked questions

Why did my claim deny when mass adjusted to apply a retroactive rate?
- Discharge status code on claims previously submitted is incorrect

Why does the patient liability appear to be deducted twice during the retro-rate adjustment?
- Liability may be deducted on a different claim for the same month during retro-rate adjustment.
- Verify retro-rate adjustments for the entire month.
Reminder
The IHCP will mandate a 180-day filing limit for fee-for-service (FFS) claims, effective January 1, 2019. Refer to BT201829, published on June 19, 2018, for additional details.

- The 180-day filing limit will be effective based on date of service:
  - Any services rendered on or after January 1, 2019, will be subject to the 180-day filing limit.
  - Dates of service before January 1, 2019, will be subject to the 365-day filing limit.

*Watch for additional communications!*
Helpful tools
Helpful tools

Provider Relations Consultants

<table>
<thead>
<tr>
<th>REGION</th>
<th>FIELD CONSULTANT</th>
<th>EMAIL</th>
<th>TELEPHONE</th>
<th>COUNTIES SERVED</th>
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<tbody>
<tr>
<td>1</td>
<td>Jean Downs</td>
<td><a href="mailto:INXIXRegion1@dxc.com">INXIXRegion1@dxc.com</a></td>
<td>(317) 488-5071</td>
<td>DeKalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Whitley Chicago, Watseka Sturgis</td>
</tr>
<tr>
<td>2</td>
<td>Shari Galbreath</td>
<td><a href="mailto:INXIXRegion2@dxc.com">INXIXRegion2@dxc.com</a></td>
<td>(317) 488-5080</td>
<td>Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware Fountaininm Grant, Howard, Huntington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White Danville</td>
</tr>
<tr>
<td>3</td>
<td>Crystal Woodson</td>
<td><a href="mailto:INXIXRegion3@dxc.com">INXIXRegion3@dxc.com</a></td>
<td>(317) 488-5324</td>
<td>Boonem Hamilton, Hendricks, Johnson, Marion, Morgan</td>
</tr>
<tr>
<td>4</td>
<td>Ken Guth</td>
<td><a href="mailto:INXIXRegion4@dxc.com">INXIXRegion4@dxc.com</a></td>
<td>(317) 488-5153</td>
<td>Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, Warrick Owensboro</td>
</tr>
<tr>
<td>5</td>
<td>Virginia Hudson</td>
<td><a href="mailto:INXIXRegion5@dxc.com">INXIXRegion5@dxc.com</a></td>
<td>(317) 488-5186</td>
<td>Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Hancock, Henry, Jackson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne Louisville Cincinnati, Harrison, Hamilton, Oxford</td>
</tr>
<tr>
<td>Team Lead</td>
<td>Jenny Atkins</td>
<td></td>
<td>(317) 488-5026</td>
<td>All other out of state areas not previously listed</td>
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Helpful tools

IHCP website at indianamedicaid.com:
• IHCP Provider Reference Modules
• Medical Policy Manual
• Contact Us – Provider Relations Field Consultants

Customer Assistance available:
• Monday – Friday, 8 a.m. – 6 p.m. Eastern Time
• 1-800-457-4584

Secure Correspondence:
• Via the Provider Healthcare Portal
• Written Correspondence:
  DXC Technology Provider Written Correspondence
  P.O. Box 7263
  Indianapolis, In 46207-7263
Questions

Following this session, please review your schedule for the next session you are registered to attend.