Home and Community-Based Services Billing Guidelines
## Revision History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Reason for Revisions</th>
<th>Completed By</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Policies and procedures as of October 1, 2015 Published: February 25, 2016</td>
<td>New document</td>
<td>FSSA and HPE</td>
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<tr>
<td>1.1</td>
<td>Policies and procedures as of September 1, 2016 <em>(CoreMMIS updates as of February 13, 2017)</em> Published: May 16, 2017</td>
<td>Scheduled update</td>
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</table>
| 3.0     | Policies and procedures as of November 1, 2018 Published: August 29, 2019 | Scheduled update  
- Added a note box with standard wording at beginning of module  
- Updated links to new IHCP website  
- Reorganized and edited text as needed for clarity  
- Removed references to the PRTF Transition Waiver  
- Added a reference to waiver liability in the [1915(c) HCBS Waiver Benefit Plans](#) section  
- Specified that 1915(i) services are carved out of managed care and reimbursed as fee-for-service in the [1915(i) HCBS Benefit Plans](#) section and the [Claim Completion for 1915(i) State Plan Services](#) section  
- Updated the [Eligibility Verification for 1915(c) HCBS Waiver and MFP Demonstration Grant Benefits](#) section and its subsections to reflect changes in how the Portal and IVR system identify Traditional Medicaid coverage with NEMT brokerage  
- In the [HCBS Waiver Liability](#) section, clarified procedures for rendering and billing services for members with an unmet waiver liability | FSSA and DXC |
<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
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</tr>
</thead>
</table>
|         |      | - Updated the *Eligibility Verification for 1915(i) HCBS Benefits* section, including:  
|         |      |   - Added *HIP Maternity* and *Hoosier Healthwise* to the list of benefit plans that allow for 1915(i) HCBS participation  
|         |      |   - Added a reminder about not duplicating services when combining HCBS benefits  
|         |      |   - Clarified the definitions for the Start Date and End Date fields in the Portal *Detail Information* panel  
|         |      | - Added a note about Portal instructions in the *Claim Completion for 1915(c) HCBS Waiver Services* section  
|         |      | - Provided a new link for the Indiana Statewide Transition Plan in the *HCBS Provider Reimbursement* section |
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Introduction

To enable individuals who qualify for institutional placement to receive services in their homes and community settings, the Indiana Health Coverage Programs (IHCP) offers the following:

- 1915(c) Home and Community-Based Services (HCBS) waiver benefits
- 1915(i) HCBS State Plan benefits
- Money Follows the Person (MFP) demonstration grant benefits

These HCBS and demonstration grant benefits are provided through three divisions of the Indiana Family and Social Service Administration (FSSA):

- Division of Aging (DA)
- Division of Disability and Rehabilitative Services (DDRS)
- Department of Mental Health and Addiction (DMHA)

The FSSA is the single State agency that serves as the umbrella for the Office of Medicaid Policy and Planning (OMPP), DA, DDRS, and DMHA. Under the direction of the Secretary of FSSA, the OMPP is responsible for administrative oversight of the HCBS and MFP benefit plans, and the three divisions are charged with day-to-day operation of the HCBS and MFP benefits.

1915(c) HCBS waivers, 1915(i) HCBS State Plan benefits, and the MFP demonstration grant are funded with state and federal dollars and are approved by the Centers for Medicare & Medicaid Services (CMS) for a specified time.

1915(c) HCBS Waiver Benefit Plans

Section 1915(c) of the Social Security Act permits states to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. The term waiver refers to the fact that the IHCP waives certain requirements applicable to Traditional Medicaid eligibility for individuals who qualify for services through a 1915(c) HCBS benefit plan.

The IHCP offers the following 1915(c) HCBS waiver benefit plans:

- Operated by the DA:
  - Aged and Disabled (A&D) Waiver
  - Traumatic Brain Injury (TBI) Waiver
- Operated by the DDRS:
  - Community Integration and Habilitation (CIH) Waiver
  - Family Supports Waiver (FSW)
All potential 1915(c) HCBS waiver participants must be enrolled in the IHCP Traditional Medicaid program. If they do not meet income requirements for Traditional Medicaid, they may be enrolled with a waiver liability – a financial obligation that they must meet each month before IHCP reimbursement begins. See the HCBS Waiver Liability section for details.

For more information about eligibility and services associated with each HCBS waiver benefit plan, see the following modules:

- Division of Aging Home and Community-Based Services Waivers
- Division of Disability and Rehabilitation Services Home and Community-Based Services Waivers

Note: The DA also operates the Money Follows the Person (MFP) demonstration grant benefit plans. MFP is a program that serves eligible members as they transition into the appropriate 1915(c) HCBS waiver benefit plan. See the Money Follows the Person Demonstration Grant section of this document for more information.

1915(i) HCBS Benefit Plans

Section 1915(i) of the Social Security Act gives states the option to offer a wide range of HCBS benefits to members through state Medicaid plans. Using this option, states can offer services and supports to target groups of individuals – including individuals with serious mental illness (SMI), emotional disturbance, or substance use disorders – to help them remain in the community.

The IHCP offers the following 1915(i) HCBS benefit plans, operated by the DMHA:

- Adult Mental Health Habilitation (AMHH) – The AMHH benefit plan provides services to adults with SMI who may most benefit from keeping or learning skills to maintain a healthy, safe lifestyle in community-based settings.
- Behavioral and Primary Healthcare Coordination (BPHC) – The BPHC benefit plan consists of the coordination of healthcare services to manage the healthcare needs of eligible members. This benefit plan includes logistical support, advocacy, and education to assist individuals in navigating the healthcare system, as well as activities that help members gain access to physical and behavioral health services needed to manage their health condition.
- Child Mental Health Wraparound (CMHW) – The CMHW benefit plan delivers individualized services to children with serious emotional disturbances (SED). The focused nature of the CMHW benefit plan is intended to better address the special needs of children and youth with SED.

All potential 1915(i) HCBS benefit participants must be enrolled in an IHCP Medicaid program; the allowable type of IHCP Medicaid program varies based on the requirements of the specific 1915(i) HCBS benefit plan. (Note that services provided under a 1915(i) HCBS program are carved out of the managed care delivery system and reimbursed as fee-for-service.) In addition, some members might be concurrently enrolled in multiple 1915(i) HCBS benefit plans, such as AMHH and BPHC. Some members receiving a 1915(i) HCBS benefit might also receive a 1915(c) HCBS waiver, but must not duplicate services. See the HCBS Benefit Combinations section.

Eligibility criteria for AMHH, BPHC, and CMHW vary based on the following:

- Income
- Age
- Total scores on the Adult Needs and Strengths Assessment (ANSA) or Child and Adolescent Needs and Strengths (CANS) assessment tool
- Level-of-need (LON) evaluations
For more information about eligibility and services associated with specific 1915(i) HCBS benefit plans, see the following modules:

- Division of Mental Health and Addiction Adult Mental Health Habilitation Services
- Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services
- Division of Mental Health and Addiction Child Mental Health Wraparound Services

**Money Follows the Person Demonstration Grant Benefit Plans**

The DA administers the MFP program, which is funded through a federal grant from the CMS. Indiana’s MFP program is specifically designed as a transition program to assist individuals who live in qualifying institutions to move safely into the community and to ensure a safe adjustment to community living.

MFP serves eligible members for up to 365 days, until they transition into the 1915(c) HCBS waiver that the grant is mirrored after. The MFP supports the following benefit plans:

- MFP – TBI
- MFP – A&D

All potential MFP demonstration grant participants must be enrolled in the IHCP Traditional Medicaid program; see the [Traditional Medicaid Coverage](#) section for details. For more information about the MFP program, see the [Money Follows the Person](#) page at in.gov/fssa.

**HCBS Benefit Combinations**

Members can be enrolled in multiple HCBS benefit plans at the same time, but services must not be duplicated. The following list shows the combinations of concurrent HCBS benefit plan enrollments that are possible for an eligible member:

- AMHH + BPHC
- CIH Waiver + AMHH
- CIH Waiver + AMHH + BPHC
- CIH Waiver + BPHC
- FSW + AMHH
- FSW + BPHC
- FSW + AMHH + BPHC
- A&D Waiver + AMHH
- A&D Waiver + BPHC
- A&D Waiver + AMHH + BPHC
- A&D Waiver + CMHW
- TBI Waiver + AMHH
- TBI Waiver + BPHC
- TBI Waiver + AMHH + BPHC
- TBI Waiver (nursing facility level of care only) + CMHW
Providers must have a thorough knowledge of the DA, DDRS, and DMHA provider reference modules, as well as the Member Eligibility and Benefit Coverage module, to be able to determine eligibility for possible IHCP Medicaid, 1915(c) HCBS waiver, and 1915(i) HCBS benefit plan and service combinations.

Authorization of Services

The following sections describe the process for authorizing specific services within the 1915(c) HCBS waiver, MFP demonstration grant, and 1915(i) HCBS benefit plans.

Authorization of 1915(c) HCBS Waiver and MFP Demonstration Grant Services

For 1915(c) HCBS waiver participants, the HCBS case or care manager is responsible for completing a plan of care/cost comparison budget (POC/CCB), which, when approved, results in an approved notice of action (NOA).

The NOA details the services and number of units or dollars to be provided, the approved date period, the name of the authorized provider, and the approved billing code with the appropriate modifiers. This data is transmitted to the Core Medicaid Management Information System (CoreMMIS) and stored in the prior authorization database. Claims deny if no authorization exists in the database or if a code other than the approved code is billed.

Providers must not render or bill HCBS waiver or MFP demonstration grant services without an approved NOA. It is the responsibility of each provider to contact the case manager in the event the services, as authorized or rendered, do not meet the definition and parameters of the services approved on the NOA.

Authorization of 1915(i) HCBS Benefit Plan Services

The authorization process for 1915(i) HCBS services varies by benefit plan:

- Authorization for AMHH services – AMHH applications are submitted through Data Assessment Registry Mental Health and Addiction (DARMHA). An eligible AMHH member is authorized to receive AMHH services on an approved Individualized Integrated Care Plan (IICP) for 1 year (360 days) from the start date of AMHH eligibility, or as determined by the DMHA State Evaluation Team (SET). Services may be provided according to the DMHA-approved IICP as long as the member continues to meet AMHH eligibility criteria. After an applicant is determined eligible for AMHH, the SET approves specific AMHH services based on review of documentation and the IICP. For additional authorization information, see the Adult Mental Health Habilitation Services page at in.gov and the Division of Mental Health and Addiction Adult Mental Health Habilitation Services module.

- Authorization for BPHC services – BPHC applications are submitted through DARMHA. The SET transmits the BPHC benefit plan and service approval to the IHCP. This approval is entered into the IHCP Provider Healthcare Portal (Portal) and a BPHC approval notice is sent to the applicant and his or her provider. The authorization notification generated includes the start and end dates for BPHC eligibility as well as the BPHC procedure codes, modifiers, and number of units approved. For additional authorization information, see the Behavioral and Primary Healthcare Coordination web page at in.gov and the Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services module.
Home and Community-Based Services Billing Guidelines

- Authorization for CMHW services – CMHW applications are submitted through the Tobi database. After the DMHA deems an applicant eligible for the CMHW benefit plan, the DMHA creates an initial intervention plan that includes 2 months of wraparound facilitation services. The Wraparound Facilitator works with the family to develop a Child and Family Team that will work together with the participant and family to develop an individualized initial plan of care (POC) and immediate crisis/safety stabilization plan. Until the initial POC is developed by the Child and Family Team and approved by the DMHA, no other CMHW service may be accessed. For additional authorization information, see the Child Mental Health Wraparound (CMHW) Services web page at in.gov/issa/dmha and the Division of Mental Health and Addiction Child Mental Health Wraparound Services module.

See the Eligibility Verification for 1915(i) HCBS Benefits section of this module for information about viewing authorized 1915(i) services in the Portal.

Eligibility Verification

All service providers must verify member eligibility before the initiation of services and on each date of service thereafter, because a member may become ineligible for services at any time.

Providers can access IHCP Eligibility Verification System (EVS) information using the following methods:

- Provider Healthcare Portal at portal.indianamedicaid.com
- Interactive Voice Response (IVR) system at 1-800-457-4584
- 270/271 electronic data interchange (EDI) transaction

See the Provider Healthcare Portal, Interactive Voice Response System, and Electronic Data Interchange modules for details about using these eligibility verification methods.

Eligibility Verification for 1915(c) HCBS Waiver and MFP Demonstration Grant Benefits

To verify eligibility for HCBS waiver or MFP demonstration grant services, providers must confirm that the member is enrolled in the IHCP Traditional Medicaid program and also has an open HCBS waiver or MFP demonstration grant level-of-care status recorded in CoreMMIS on the date of service. The eligibility verification process will also indicate whether the member has unmet waiver liability for the month. Providers must also confirm that the specific waiver service has been approved for the member.

Traditional Medicaid Coverage

The EVS identifies Traditional Medicaid enrollment as either Full Medicaid or Package A – Standard Plan coverage within the fee-for-service delivery system. Note that these same benefit plans are also available under the Hoosier Care Connect and Hoosier Healthwise managed care programs. Therefore, verifying Full Medicaid or Package A – Standard Plan coverage is not sufficient to confirm Traditional Medicaid coverage; providers must also confirm that the coverage is fee-for-service.

Although Traditional Medicaid is a fee-for-service program, most nonemergency medical transportation (NEMT) services provided under Traditional Medicaid are subject to brokerage requirements, as described in the Transportation Services module. As a result, the following managed care responses are returned for Traditional Medicaid members:

- On the IVR system – “The member is in managed care. The managed care program is fee-for-service NEMT from <date> through <date>. The managed care entity is Southeastrans Incorporated.”
- On the Portal – The Managed Care Assignment Details panel indicates “Fee for Service + NEMT,” as shown in Figure 1.
Figure 1 – Portal Managed Care Assignment Details for Traditional Medicaid Coverage

<table>
<thead>
<tr>
<th>Managed Care Assignment Details</th>
<th>Primary Medical Provider</th>
<th>Provider Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Program</td>
<td>Effective Date</td>
<td>End Date</td>
</tr>
<tr>
<td>Fee for Service + NEMT</td>
<td>06/21/2010</td>
<td>06/21/2018</td>
</tr>
</tbody>
</table>

Note: Transportation authorized by the NOA is not subject to brokerage requirements. However, medically necessary NEMT for nonwaiver services remain brokered for HCBS waiver members.

HCBS waiver and MFP demonstration grant members cannot be enrolled in a managed care program. Providers should verify member eligibility on the 1st and 15th calendar days of the month, because member eligibility in managed care is effective on those days. If a member is enrolled in the HIP, Hoosier Care Connect, or Hoosier Healthwise managed care program, contact that member’s managed care entity (MCE) immediately to disenroll the member from managed care. MCE contact information is included in the IHCP Quick Reference Guide, available at in.gov/medicaid/providers.

HCBS Waiver or MFP Demonstration Grant Level of Care

For members with an open HCBS waiver LOC, the EVS identifies the coverage using one of the following benefit plan names:

- Aged and Disabled HCBS Waiver
- Community Integration and Habilitation HCBS Waiver
- Family Supports HCBS Waiver
- Traumatic Brain Injury HCBS Waiver

For members with an open MFP demonstration grant LOC, the EVS identifies the coverage using one of the following benefit plan names:

- MFP Demonstration Grant HCBS Waiver
- MFP Traumatic Brain Injury

Note: DXC Technology cannot add or correct an HCBS waiver or MFP demonstration grant level-of-care segment in CoreMMIS (or corresponding benefit plan in the EVS). Providers may contact the INsite Helpdesk at insite.helpdesk@fssa.in.gov to initiate corrections to an HCBS waiver or MFP demonstration grant level-of-care segment.

Figure 2 shows Portal eligibility verification for a member who has HCBS A&D Waiver coverage.

Figure 2 – Portal Benefit Details Example with HCBS Waiver Coverage
**Authorized Services**

Providers must refer to the NOA for information about specific services approved for the member’s HCBS waiver or MFP demonstration grant.

**HCBS Waiver Liability**

Members with an HCBS waiver liability are responsible for payment of all IHCP services until they have met their waiver liability for the month. Until this monthly obligation has been met, neither Full Medicaid/Package A nor HCBS waiver services are reimbursable by the IHCP.

Providers must listen for waiver liability information on the IVR system or, in the Portal, click to expand and review the *Waiver Liability Details* panel (Figure 3), which shows the monthly waiver obligation and the member’s balance that remains due for the month. If a balance remains for the member, the provider should render the service and bill the IHCP as usual. After the claim is processed, the provider may then bill the member for any zero-paid amount that was credited toward the member’s monthly liability.

![Figure 3 – Portal Waiver Liability Details](image)

**Eligibility Verification for 1915(i) HCBS Benefits**

Members must be enrolled in the Traditional Medicaid program, *Healthy Indiana Plan (HIP) State Plan – Plus, HIP State Plan – Basic, HIP Maternity, Hoosier Healthwise,* or *Hoosier Care Connect* to be eligible for 1915(i) HCBS benefits. For these members, the EVS indicates coverage through both the applicable IHCP Medicaid benefit plan as well as the 1915(i) HCBS benefit plan.

The EVS identifies 1915(i) HCBS coverage using following benefit plan names:

- Adult Mental Health Habilitation
- Behavioral & Primary Healthcare Coordination
- Children’s Mental Health Wraparound

**Note:** As described in the *HCBS Benefit Combinations* section, a member may have coverage from multiple 1915(i) HCBS benefit plans simultaneously, and may have 1915(c) HCBS waiver coverage at the same time as 1915(i) HCBS coverage as long as there is not a duplication of services.
Figure 4 shows Portal eligibility verification with coverage details for a member who has AMHH coverage.

**Figure 4 – Portal Benefit Details Example with 1915(i) HCBS Coverage**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Description</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health Habilitation</td>
<td>Authorized adult Mental Health Habilitation services found in the Notice of Action (NOA)</td>
<td>11/01/2017</td>
<td>11/01/2017</td>
</tr>
<tr>
<td>Full Medicaid</td>
<td>Full Medicaid for individuals who are 65 years old, blind, or disabled (FPS or Managed Care)</td>
<td>11/01/2017</td>
<td>11/01/2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Copayments</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Medicaid</td>
<td>Medically Related Transportation</td>
<td>$2.00</td>
</tr>
<tr>
<td>Full Medicaid</td>
<td>Hospital - Outpatient</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

If the provider performing the Portal eligibility verification is an AMHH, BPHC, or CMHW provider, the 1915(i) HCBS benefit plan name will appear as a hyperlink in the Benefit Details panel (Figure 4). The provider can click the benefit plan name to view the Detail Information panel, which shows the specific services that have been authorized for the member under that benefit plan (Figure 5).

**Figure 5 – Portal Detail Information for an AMHH Member**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Code</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Units Authorized</th>
<th>Units Used</th>
<th>Amount Authorized</th>
<th>Amount Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXXXXXX</td>
<td>HC034 UB</td>
<td>MED TRNG &amp; SUPPORT PER 15MIN</td>
<td>10/15/2018</td>
<td>10/18/2017</td>
<td>725</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>X0XXXXX</td>
<td>HC014 UB</td>
<td>SKILLS TRAIN AND DEV. 15 MIN</td>
<td>10/15/2018</td>
<td>10/18/2017</td>
<td>2920</td>
<td>43</td>
<td>$501.22</td>
<td>-</td>
</tr>
</tbody>
</table>

The Detail Information panel lists each service that has been authorized for that member under the 1915(i) HCBS benefit plan selected, including the following information:

- **Provider** – Practitioner or entity that requested the PA
- **Code** – Procedure code and modifiers for the approved service
- **Description** – Description of the approved service
- **Start Date** – The effective date of the service approval; services rendered prior to this date are not considered for reimbursement
- **End Date** – The end date of the service approval; services rendered after this date are not considered for reimbursement
- **Units Authorized** – The number of units that are approved for this service
- **Units Used** – The number of units of this service that have been used
- **Amount Authorized** – The dollar amount that is approved for this service
- **Amount Used** – The dollar amount of this service that has been used

*Note: The Units Used and Amount Used information displayed is based on paid claims only.*

The Detail Information panel is only available for 1915(i) HCBS and Medicaid Rehabilitation Option (MRO) benefit plans. For information about services authorized for 1915(c) HCBS waiver or MFP benefit plans, providers must consult the member’s NOA.
HCBS Billing Instructions

HCBS claims are billed as professional claims on the Portal, 837P electronic transaction, or CMS-1500 claim form. DXC and the FSSA recommend submitting claims electronically. See the Provider Healthcare Portal module or the Electronic Data Interchange module, or contact a provider field consultant for more information. For general information about billing professional, fee-for-service claims, see the Claim Submission and Processing module.

Procedure Codes and Modifiers

Services provided under the 1915(i) and 1915(c) benefit plans are limited to the procedure code/modifier combinations approved for the individual member. Providers must consult the NOA (or, for AMHH, BPHC, and CMHW members, the Detail Information panel on the Portal eligibility verification) to determine the procedure code/modifier combinations approved to bill for the member under that benefit plan.

Units of Service

If a unit of service equals 15 minutes, a minimum of 8 minutes must be provided to bill for one unit. Activities requiring less than 8 minutes may be accrued to the end of that date of service. At the end of the day, partial units may be rounded as follows: units totaling more than 8 minutes may be rounded up and billed as one unit. Partial units totaling less than 8 minutes may not be billed.

Billing with IHCP Provider ID or NPI

The following sections explain which HCBS providers should bill using a National Provider Identifier (NPI) and which HCBS providers should bill using an IHCP Provider ID.

Waiver Providers Use Provider ID to Bill HCBS Waiver Claims

Waiver providers are considered to be atypical providers and must bill claims for HCBS waiver services using the IHCP Provider ID. Waiver providers that bill with an NPI associated with multiple Provider IDs must ensure that a taxonomy code is not indicated on the HCBS waiver claim.

Note: If the taxonomy code is included on a claim for HCBS waiver services, payment may be made to the wrong service provider.

Example: A provider performs both HCBS waiver and Medicaid home health services. Both services would use the same NPI for billing and have the same ZIP Code. When submitting claims, the home health provider must bill using the NPI and the taxonomy code. The waiver provider bills using the NPI without the taxonomy code (or, preferably, the Provider ID instead of the NPI). If the waiver claim is billed with the NPI and a taxonomy code, payment is sent to the home health provider.

Providers Use NPI to Bill 1915(i) HCBS Claims

AMHH, BPHC, and CMHW providers are considered typical providers and must bill HCBS claims using the NPI.
Third-Party Liability Exemption

The IHCP will not bill private insurance carriers through the third-party liability (TPL) or reclamation processes for claims containing any HCBS benefit modifier codes. This exemption includes procedure code–modifier combinations specific to claims for the following benefit plans:

- AMHH
- A&D Waiver
- BPHC
- CMHW
- CIH Waiver
- FSW
- MFP A&D
- MFP TBI
- TBI Waiver

Claim Completion for 1915(i) State Plan Services

For 1915(i) State Plan HCBS claims, including claims for AMHH, BPHC, and CMHW services, providers follow the general instructions for professional claim completion.

1915(i) HCBS program services are carved out of the managed care delivery system. Therefore, these services must be billed to DXC as fee-for-service claims for all members, including those enrolled in a managed care program.

Claim Completion for 1915(c) HCBS Waiver Services

Table 1 lists the required fields for billing HCBS waiver services on the CMS-1500 claim form. The table provides instructions for each required field. The IHCP strongly advises providers to complete only the designated fields in Table 1 for HCBS waiver billing. Completing fields not listed in the table could result in claim denial. A copy of the CMS-1500 claim form follows the table (see Figure 6).

Note: The same general instructions as those in the following table also apply to HCBS waiver claims submitted via the Portal. However, some fields in the Portal may have slightly different names, appear in a different order, or require the information be submitted in a different format than on the paper claim form. Additionally, some fields in the Portal are autofilled based on provider and member information stored in CoreMMIS. See the Provider Healthcare Portal module for more information.
<table>
<thead>
<tr>
<th>Form Field</th>
<th>Description</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>TYPE OF INSURANCE COVERAGE</td>
<td>Enter X in the Medicaid box.</td>
</tr>
<tr>
<td>1a</td>
<td>INSURED’S I.D. NUMBER</td>
<td>Enter the 12-digit IHCP Member ID (also known as RID).</td>
</tr>
<tr>
<td>2</td>
<td>PATIENT’S NAME</td>
<td>Enter the member’s last name, first name, and middle initial. (The name on the claim must exactly match the name as it appears on the member ID card.)</td>
</tr>
<tr>
<td>17</td>
<td>NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td>Enter the name of the waiver case manager, <em>not</em> a physician’s name. (Optional)</td>
</tr>
<tr>
<td>17a</td>
<td>[ID NUMBER OF REFERRING PROVIDER OR OTHER SOURCE]</td>
<td>Enter the qualifier 1D or G2 in the first box of field 17a, followed by the case manager’s Provider ID, which is listed on the member’s NOA. (Optional)</td>
</tr>
</tbody>
</table>
| 21        | DIAGNOSIS OR NATURE OF ILLNESS OR INJURY        | • Enter R69 in field 21, line A, as the diagnosis for all waiver or demonstration grant members, if the actual diagnosis code is not known.  
• In the ICD Ind. field, enter 0 to indicate ICD-10 diagnosis codes. |
| 24A       | DATE(S) OF SERVICE                               | Enter the month, day, and year for the *from* and *to* dates that are applicable to the billing period for each service rendered.  
• Use the six-digit MM/DD/YY format.  
• Always complete the *from* and *to* dates.  
• Bill consecutive dates of service for the same procedure code and same month on a single line.  
• Bill multiple months on separate lines. |
| 24B       | PLACE OF SERVICE                                 | Enter the appropriate two-digit code from the following list:  
• 11 – Office/Clinic  
• 12 – Home |
<p>| 24D       | PROCEDURES, SERVICES, OR SUPPLIES                | Use <em>only</em> waiver service procedure codes, exactly as they are shown on the approved NOA. Place the procedure code in the left side of field 24D under CPT/HCPCS. Enter the appropriate modifier(s) in the right side of field 24D, under MODIFIER. |
| 24E       | DIAGNOSIS POINTER                               | Enter A referring to field 21 where R69 (or other appropriate diagnosis code) was entered. |
| 24F       | CHARGES                                          | Enter the total charge for this service, based on the number of units billed in field 24G. |
| 24G       | DAYS OR UNITS                                    | Enter the total number of units, in whole units only, for the service date or dates on that line. See the NOA for unit duration for each code billed. |</p>
<table>
<thead>
<tr>
<th>Form Field</th>
<th>Description</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>24I</td>
<td>ID QUAL</td>
<td>Enter qualifier 1D or G2 in this field.</td>
</tr>
</tbody>
</table>
| 24J        | RENDERING PROVIDER ID # | Enter the IHCP Provider ID for the rendering. The following explains which rendering Provider ID is used, depending on the type of provider billing:  
- For agencies billing case management services, the rendering Provider ID is the case manager’s Provider ID  
- For Area Agencies on Aging (AAA) billing for services other than case management, the rendering Provider ID is the agency’s rendering number issued by DXC.  
- For all group providers, the rendering Provider ID is the agency’s rendering number issued by DXC. The rendering Provider ID must be linked to the group number in CoreMMIS.  
- For all sole proprietors or billing providers, the rendering Provider ID is the waiver Provider ID. |
| 24J        | RENDERING PROVIDER NPI | Leave this field blank. Waiver providers should not use the NPI. |
| 28         | TOTAL CHARGE | Enter the sum of all the amounts (each detail line) in field 24F. |
| 29         | AMOUNT PAID | For all HCBS waiver claims, including those members with HCBS waiver liability, always enter $0. |
| 31         | SIGNATURE OF PHYSICIAN OR SUPPLIER | IHCP participating providers must have a signature on file; therefore, this field is optional. |
| 33         | BILLING PROVIDER INFO & PHONE # | Enter the billing provider service location name, address, and nine-digit ZIP Code + 4. |
| 33a        | BILLING PROVIDER NPI | Leave this field blank. Waiver providers should not use the NPI. |
| 33b        | [BILLING PROVIDER Qualifier AND ID NUMBER] | Enter the qualifier 1D or G2 and the billing Provider ID.  
**Note:** Do not use the rendering Provider ID listed in field 24J in field 33b unless the provider is a sole proprietor or a billing provider. |
Providers should submit the completed CMS-1500 claim form, along with any additional required documentation, to the following address:

**DXC CMS-1500 Claims**  
P.O. Box 7269  
Indianapolis, IN 46207-7269
Supporting Documentation

Supportive documentation is required when billing for HCBS benefit plan services. The documentation should include the following:

- Complete date of service, including month, day, and year
- Time entry for service provided, including the time in and time out
  - Providers should note a.m. and p.m., as appropriate, unless using 24-hour time notations.
  - Providers should ensure consistent notation of time – standard notation or 24-hour notation
- Number of units of service delivered on that date
- Specific goal on the individual’s person-centered plan that the service addressed
- Signature of any staff member providing the service or making entries into the documentation
  - Signature must include a minimum of the first initial and last name
  - Signature must include the staff member’s certification or title

Note: For service providers that use electronic signatures for documentation, a specific policy must be in place specifying how electronic signatures will be established, controlled, and verified. For citations specific to documents transmitted to the State, see the following sections of Indiana Code (IC):

- Electronic Digital Signatures Act (IC 5-24)
- Uniform Electronic Transactions Act (IC 26-2-8)

In addition, the State Board of Accounts has promulgated a rule with additional regulations, which can be found at Indiana Administrative Code 20 IAC 3.

Providers are required to verify the specifications for documentation standards for all HCBS benefit plans the provider is authorized to operate. See the individual HCBS program modules on the IHCP Provider Reference Modules page at in.gov/medicaid/providers for documentation requirements and standards specific to each HCBS benefit plan.

Special Processing for HCBS Provided on Long-Term Care Discharge Dates or During Hospice Level of Care

It is appropriate for transition-related HCBS benefit plan services to be provided on the same day a long-term care (LTC) member discharges. Provision of certain HCBS benefit plan services to members with a hospice level of care may also be appropriate. Payment for services provided under either of these circumstances will be systematically denied unless specially handled.

Providers submitting claims for HCBS benefit plan services on the member’s date of discharge from the LTC facility or during a period of hospice level of care should contact their Provider Relations field consultant for special claim handling. Providers that have had claims previously denied for situations such as these should also contact their field consultant for special handling. To locate the field consultant assigned to your area, see the Provider Relations Field Consultants page at in.gov/medicaid/providers.
When using the Portal to verify eligibility, hospice and LTC level-of-care information appears in the Nursing Home/Hospice Level of Care panel (Figure 7) in the coverage details.

![Figure 7 – Nursing Home/Hospice Level of Care Coverage Details]

### Paid Claim Adjustments

Claim adjustments are necessary when a provider needs to make corrections to a claim that has already been submitted. See the **Claim Adjustments** module for information on submitting adjustments.

### HCBS Provider Reimbursement

The IHCP reimburses HCBS providers for covered services they provide to HCBS members using a standard, statewide rate-setting methodology. The FSSA establishes HCBS rates and rate capitations.

To receive appropriate reimbursement, the Medicaid-enrolled HCBS provider must bill only those services and procedure codes authorized on the approved NOA and listed on the member’s prior authorization file (and, for AMHH, BPHC, and CMHW services, the Detail Information panel on the Portal eligibility verification). Providers must ensure the documentation of the service rendered and the procedure code billed are in accordance with the service definition and parameters as published in the specific HCBS provider module.

HCBS benefit services shall not be provided in any institutional settings. If a member is admitted to an institutional setting, such as a hospital, nursing facility, or correctional facility, an HCBS provider may not render nor receive reimbursement for HCBS benefit plan services while the member is institutionalized. Some exceptions exist under certain circumstances, such as with transition case management or respite services provided in institutional settings. For allowable HCBS settings for benefits, HCBS providers must have a thorough knowledge of the Indiana Statewide Transition Plan (available on the Home and Community-Based Services Final Rule Statewide Transition Plan page at in.gov/fssa) as well as the respective DA, DDRS, and DMHA provider modules:

- **Division of Aging Home and Community-Based Services Waivers**
- **Division of Disability and Rehabilitative Services Home and Community-Based Services Waivers**
- **Division of Mental Health and Addiction Adult Mental Health Habilitation Services**
- **Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services**
- **Division of Mental Health and Addiction Child Mental Health Wraparound Services**