Home Health, Hospice, and Nursing Facility
Agenda

- Billing Tips
- Home Health
- Hospice
- Nursing Facility
- Claim Form Update
- Helpful Tools
- Questions
Billing Tips
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

2/7/2013 - The Indiana Health Coverage Programs (IHCP) previously identified that the federal poverty level (FPL) income
# Medical Policy Manual

**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

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<th>Name</th>
<th>Effective Date</th>
<th>Version</th>
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<td>July 2017</td>
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Provider Reference Materials

Provider modules are available at indiana-medicaid.com – see Provider Reference Materials quick link.
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
Home Health – Overhead

- 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

Occurrence code 73 and 61 are date of service (DOS)-driven
- DOS on or after February 13, 2017, use occurrence code 73
- DOS before February 13, 2017, use occurrence code 61
- If the dates of service billed are not consecutive, enter occurrence code, and the date for each date of service
- If the dates of service are consecutive, enter occurrence code and the occurrence span dates
Enter individual service dates if not billing all dates within a time-span

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Enter a span of service dates when billing for **ALL** dates within a time-span

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Home Health – Overhead Paper Billing

Occurrence code 73 (or 61) and individual dates

Occurrence code 73 (or 61) and date span
Home Health – Face-to-Face Policy Requirements

• Documentation of face-to-face encounter is required no more than 90 days before or 30 days after the start of service
  – Use code 50 for dates of service prior to February 13, 2017

• Face-to-Face requirement does not apply to HCBS waiver home health services
Home Health – Prior Authorization Bypass

• Services within 30 days of hospital discharge with physician order for home health service
  – If services will exceed 30 days a face to face is required
• RN, LPN, or home health aide not to exceed 120 hours
• Any combination of therapy services not to exceed 30 units
• Enter occurrence code 42 and the date of inpatient discharge on each claim for bypass for dates of service on or after February 13, 2017
  – Use 50 for dates of service February 12, 2017, or prior
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 in the PA request

The hospice provider must submit the hospice plan of care and the home health plan of care to the Indiana Health Coverage Program Fee For Service Prior Authorization vendor, Cooperative Managed Care Services, to ensure a comprehensive review
Home Health – Managed Care

• For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, bill the appropriate managed care entity (MCE)

• [indianamedicaid.com](http://indianamedicaid.com) > Contact Us
  – Contact information for the MCEs
  – Provider field consultants for the MCEs
Hospice
Hospice – Election

- Member must elect hospice services by completing a *Medicaid Hospice Election State Form 48737 (R2/1-12)*
  - Form can be downloaded from the [Forms](mailto:https://indianamedicaid.com) page at indianamedicaid.com
Hospice – Election

• Indicating a particular hospice provider – 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
  - 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 – General Information

• 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 services include, but are not limited to:
  – Palliative care for physical, psychological, social, and spiritual needs of the patient

• Hospice providers can provide hospice care to an IHCP member:
  – In an inpatient setting
  – In an Nursing facility setting
  – In the member’s home
Hospice – Election for Members 20 Years or Younger

• 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 available
  – Palliative treatment and management of terminal condition supervised by hospice provider
  – Curative care services covered separately by the IHCP
Hospice – Election for Members 20 Years or Younger

- Hospice plan of care and a curative plan of care must both be submitted for PA review
  - *Medicaid Hospice Plan of Care for Curative Care – Members 20 Years and Younger* – Available on the [Forms](https://indianamedicaid.com) page at indianamedicaid.com

- No changes to hospice billing
  - Curative care services reimbursed separately
Hospice – Service Intensity Add On (SIA)

- SIA is billed with revenue codes 551 or 561
- Must be billed as detail line items on the claim
- Must include discharge status codes 20, 40, 41, or 42
Hospice – (SIA)
Discharge Service Code Update

• Revenue codes 651 and 653 must include occurrence code 55 for DOS on or after February 13, 2017
  – Use occurrence code 51 for DOS before February 13, 2017

• Live discharge revenue code 651 and 653 must include occurrence code 42 for DOS on or after February 13, 2017
  – Use occurrence code 51 for DOS before February 13, 2017
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
- Family Planning eligibility program
Hospice – Right Choices Members

Right Choices Members must be disenrolled from Managed Care to receive Hospice benefits. On receipt of hospice election paperwork, Cooperative Managed Care Services (CMCS) contacts the RCP Administrator to request that the member be disenrolled from the RCP

• Hospice providers should follow up with CMCS staff to confirm managed care disenrollment is in process
Hospice – Healthy Indiana Plan Members

- Hospice providers must identify the HIP member’s HIP insurance plan
- Prior authorization and claims payment must be directed to the HIP member’s specific plan
- A hospice provider must ensure that it is a HIP-enrolled provider within the HIP member’s plan
- Specific information about HIP and the distinct plans that administer HIP can be found on the Healthy Indiana Plan page at indianamedicaid.com
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
In-home and institutional Hospice Care are not covered benefits for Hoosier Healthwise members.

Members must be disenrolled from managed care.
Hospice – HCC and HHW Disenrollment

- For members to be disenrolled from managed care:
  - Fax member enrollment information to the IHCP PA contractor, CMCS.
  - CMCS hospice analysts contact Maximus on the same day
  - The hospice provider may start billing the IHCP the day after the individual is disenrolled from managed care

- It is imperative that hospice providers type Hospice Member Disenrollment from Managed Care in the subject line of the fax.
Nursing Facility
Nursing Facility

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:

• Pre-admission screening (PAS) for long-term care services is required for placement in an NF or pre-admission screening resident review (PASRR) for continued stay

• To access the required documents, visit the FSSA website

• Package C members do not have coverage for nursing facility care

An approved Nursing Facility Level of Care is required for IHCP reimbursement
NF – 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
NF – 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
• Use of 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
NF and Hospice

• NF 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
  – Submit claims with the appropriate discharge status code for hospice services
  – Retro-rate adjustments
  – Hospice claims billed under bill type 822, and for hospice revenue codes 653, 654, 659, 183, and 185, are automatically mass adjusted
  – Retro-rate mass adjustment ICNs begin with “55”
NF – Managed Care

- Hoosier Care Connect and Hoosier Healthwise members can obtain nursing facility coverage for short-term stays of 30 days or less
  - The MCEs will notify the FSSA of any member requiring a stay longer than 30 days
  - MCEs can request that a member be disenrolled from managed care
  - If approved by the FSSA, the MCE will work with the FSSA to initiate disenrollment

- Healthy Indiana Plan
  - Covers up to 100 skilled nursing facility days per year
  - No coverage for custodial care or room and board
NF – Frequently Asked Questions

Why did my NF claim deny when mass adjusted to apply a retroactive rate?

– LOC eligibility could have been inadvertently altered
– Discharge status code on claims previously submitted is incorrect

Patient liability appears to be deducted twice during the retro-rate adjustment – why?

– Liability may be deducted on a different claim for the same month during retro-rate adjustment
– Verify retro-rate adjustments for the entire month
Claim Form Update
Effective January 1, 2018 the IHCP will require the below claim types to be submitting for processing on the appropriate red and white forms.

- **CMS-1500 (02-12)** – professional claims
- **UB-04 (CMS-1450)** – institutional claims
- The IHCP will no longer accept copied (black and white) claim forms on or after January 1, 2018.
- Claims not received on the red-and-white claim form on or after January 1, 2018, will be returned to the provider.
Helpful Tools
Helpful Tools

• IHCP website at indianamedicaid.com
  – *IHCP Provider Reference Modules*
  – *Medical Policy Manual*
• Customer Assistance available 8am-6pm EST Monday – Friday
  – 1-800-457-4584
• IHCP Provider Relations Field Consultants
  – See the *Provider Relations Field Consultants* page at indianamedicaid.com
• 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