*Core*MMIS bulletin

Core benefits – Core enhancements – Core communications

INDIANA HEALTH COVERAGE PROGRAMS BT201693 DECEMBER 20, 2016

Clarification of *Core*MMIS billing guideline changes for home health and hospice services

In *Core*MMIS *Bulletin BT201669,* the Indiana Health Coverage Programs (IHCP) issued revised billing guidance for home health and hospice services to support the new *Core*MMIS claim-processing system. Providers were instructed to use different occurrence codes when billing for some of these services. The guidance, however, failed to indicate that use of those new occurrence codes applied only to dates of service (DOS) on or after the *Core*MMIS implementation date. The *Core*MMIS billing guidance for home health and hospice services is restated here with this important clarification added. The following guidance supersedes that published in *BT201669*.

Home health billing

With *Core*MMIS implementation, changes are being made to billing guidance for home health services.

Home health overhead occurrence codes

With the implementation of *Core*MMIS, providers must bill home health overhead with **occurrence code 73** (rather than with occurrence code 61) **for DOS on or after the *Core*MMIS implementation date**. **Occurrence code 61** should continue to be billed for home health overhead **for DOS before the *Core*MMIS implementation date**. Providers cannot bill overhead for an occurrence span that includes DOS before *Core*MMIS implementation in combination with DOS on or after *Core*MMIS implementation; overhead for these encounters must be billed separately with the appropriate occurrence code (61 or 73) indicated.

The following guidance and reminders should be considered when billing home health overhead:

- Providers may report only one overhead per provider, per member, per day. Providers use the occurrence code, occurrence date, and occurrence span on the *UB-04* claim form to indicate the appropriate overhead fee.
- Occurrence code 61 or 73 indicates that one encounter with the member occurred on the date of service (DOS) shown or on each DOS during the span date shown.

- If the dates of service billed are not consecutive, the provider should list each DOS and enter the appropriate occurrence code (61 or 73) for each encounter.
- If the dates of service billed are consecutive and do not span the *Core*MMIS implementation date, and if one encounter was provided per day, providers should enter the appropriate occurrence code (61 or 73) for the span date.
- Providers that submit more than one *UB-04* claim for a multiple-member care situation should report the overhead on only one of the claims. As long as the overhead is reported for only one member, it does not matter which member.

Home health occurrence codes to bypass PA for post-discharge services

Providers are reminded that per *Indiana Administrative Code (IAC) 405 IAC 5-16-3*, members who are discharged from a hospital are allowed home health services without prior authorization (PA) for 30 calendar days following discharge, if the physician orders the service in writing prior to the member's discharge and the member is homebound. Qualifying services are limited as follows:

- Registered nurse (RN), licensed practical nurse (LPN), or home health aide services not to exceed 120 units
- Any combination of therapy services not to exceed 30 units

Providers must bill home health services that meet the parameters to bypass PA **with occurrence code 42** (rather than with occurrence code 50), **for DOS on or after the *Core*MMIS implementation date**. **Occurrence code 50** should continue to be billed for home health services rendered on **DOS before the *Core*MMIS implementation date**. Providers should bill the appropriate occurrence code (42 or 50) with the corresponding date of discharge. When a provider bills for services exceeding the limitations and no PA is on file for the excess units, *Core*MMIS will automatically deny the excess units.

Hospice services billing

With *Core*MMIS implementation, several changes are being made to billing guidance for hospice services. Billing instructions have been adapted to include more descriptive occurrence codes and patient discharge status codes.

- Service intensity add-on (SIA) revenue codes 551 or 561 must include a **patient discharge status code of 20, 40, 41, or 42** (previously, only code 20 was used). The additional patient discharge status codes may be used on all hospice claims processed in *Core*MMIS, regardless of DOS.
- SIA revenue codes 551 or 561 must continue to include **occurrence code 55** and the date of death/discharge, regardless of DOS.
- Revenue codes 651 and 653 must include **occurrence code 55** (rather than code 51) **for DOS on or after the *Core*MMIS implementation date**. **Occurrence code 51** should continue to be billed for hospice services

rendered on **DOS before the *Core*MMIS implementation date**. The appropriate occurrence code (51 or 55) must be billed with the date of death/discharge.

- For live discharges, revenue codes 651 and 653 must include **occurrence code 42** (rather than code 51) **for DOS on or after the *Core*MMIS implementation date**. **Occurrence code 51** should continue to be billed for hospice services rendered on **DOS before the *Core*MMIS implementation date**. For live discharges, the appropriate occurrence code (42 or 51) must be billed.

Providers should ensure that billing staff or vendors are familiar with new guidance issued through *Core*MMIS *Bulletins*. *Core*MMIS billing guidance will apply to all claims, whether they are submitted through an 837 electronic data interchange (EDI) transaction, data entry in the new Portal, or paper claim forms.

QUESTIONS?

For additional questions about *Core*MMIS, email incoremmis2015im@hpe.com.

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