INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Home and Community-Based Services Billing Guidelines

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of September 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: May 16, 2017	Semiannual update: • Reorganized and edited text throughout for clarity and consistency • Replaced Web interChange references with Provider Healthcare Portal • Replaced Indiana*AIM* references with *Core*MMIS • Replaced LPI references with Provider ID • Added notation regarding PRTF Transition Waiver • Removed references to MFA-CIH and MFA-PRTF • Added the *HCBS Benefit Combinations* section • Added web page references to the *Authorization of 1915(i) HCBS Benefit Plan Services* section • Added the *HCBS Eligibility Verification* heading and expanded information in that section to reflect *Core*MMIS processes • Updated the *HCBS Billing Instructions* section, including: – Updated Table 1 – Expanded information in the *Special Processing for HCBS Provided on Long-Term Care Discharge Dates or During Hospice Level of Care* section – Added the *Third-Party Liability Exemption* section • Updated the *HCBS Provider Reimbursement* section	FSSA and HPE

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Home and Community-Based Services Billing Guidelines

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

The FSSA is the single State agency that serves as the umbrella for the Office of Medicaid Policy and Planning (OMPP), DDRS, DMHA, and DA. 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 the following 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)
- Operated by the DMHA:
  - Psychiatric Residential Treatment Facility (PRTF) Transition Waiver

Note: The PRTF Transition Waiver was discontinued in December 2016.

All potential HCBS waiver recipients must be enrolled in the IHCP Traditional Medicaid program; see the *Traditional Medicaid Coverage* 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*
- *Division of Mental Health and Addiction Psychiatric Residential Treatment Facility Transition Waiver*

> *Note: The Division of Aging 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, emotional disturbance, or substance use disorders – to help them remain in the community.

Indiana administers the following 1915(i) HCBS benefit plans through the DMHA:

- Adult Mental Health Habilitation (AMHH) – The AMHH benefit plan provides services to adults with serious mental illness (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 recipients 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. 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

The DA administers the Money Follows the Person (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 recipients 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 a 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 + CMHW

Note:	*A member cannot be enrolled in two 1915(c) HCBS waiver benefit plans at the same time.*

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 Money Follows the Person Demonstration Grant Services

The HCBS case 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 (*Core*MMIS) 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 one 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 Provider Healthcare 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 code, 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.

- 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 two 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 and the *Division of Mental Health and Addiction Child Mental Health Wraparound Services* module.

HCBS 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 any of the following methods:

- Provider Healthcare Portal (Portal) at 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

Members must be enrolled in the IHCP fee-for-service (FFS) Traditional Medicaid program (indicated on the EVS as either *Full Medicaid* or *Package A – Standard Plan* coverage with no managed care details) and also have an open HCBS waiver level-of-care status recorded in *Core*MMIS (indicated on the EVS as an HCBS waiver or MFP benefit plan) on the date of service to be eligible for HCBS waiver or MFP demonstration grant services.

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

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

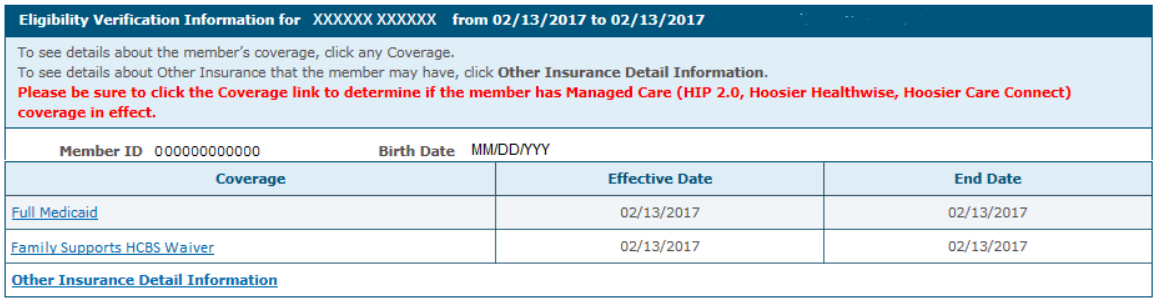
The EVS identifies MFP demonstration grant coverage using following benefit plan names:

- MFP Demonstration Grant
- MFP Traumatic Brain Injury

Note:	*Hewlett Packard Enterprise 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 via email at insite.helpdesk@fssa.in.gov to initiate corrections to an HCBS waiver or MFP demonstration grant level-of-care segment.*

Figure 1 shows Portal eligibility verification for a member with Full Medicaid and FSW coverage.

Figure 1 – Portal Eligibility Verification Showing HCBS Waiver Coverage



Eligibility Verification Information for XXXXXX XXXXXX from 02/13/2017 to 02/13/2017

To see details about the member's coverage, click any Coverage.
To see details about Other Insurance that the member may have, click **Other Insurance Detail Information**.
Please be sure to click the Coverage link to determine if the member has Managed Care (HIP 2.0, Hoosier Healthwise, Hoosier Care Connect) coverage in effect.

Member ID 000000000000 **Birth Date** MM/DD/YYY

Coverage	Effective Date	End Date
Full Medicaid	02/13/2017	02/13/2017
Family Supports HCBS Waiver	02/13/2017	02/13/2017

Other Insurance Detail Information

Traditional Medicaid Coverage

Note that both the Full Medicaid and Package A – Standard Plan benefit plans can be either FFS (if the member is enrolled in Traditional Medicaid) or managed care (if the member is enrolled in Hoosier Care Connect or Hoosier Healthwise). The appearance of Full Medicaid or Package A – Standard Plan alone is not sufficient to confirm Traditional Medicaid coverage; providers must also confirm that the coverage is FFS, as follows:

- On the IVR system, providers must listen to confirm that no managed care limitations are indicated for the member.
- On the Portal, providers click the *Full Medicaid* or *Package A – Standard Plan* link in the Coverage column of the eligibility verification information (see Figure 1) to view coverage details (see Figure 2). If no Managed Care Assignment Details panel appears, the coverage is FFS, indicating that the member is enrolled in the Traditional Medicaid program.

Figure 2 – Portal Coverage Details Showing Traditional Medicaid Coverage (Full Medicaid without Managed Care)

Coverage Details for XXX XXXXXX from 03/01/2006 to 12/31/9999 Back to Eligibility Verification Request

Expand All | Collapse All

Verification Response ID

Benefit Details

Coverage	Description
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)

Limit Details

Waiver Liability Details

Demographic Details

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 of the month, because member eligibility in managed care is effective on the first and fifteenth calendar days of the month. If a member is enrolled in a 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 indianamedicaid.com.

HCBS Waiver Liability

It is important to remember that members with HCBS waiver liability are not eligible for Full Medicaid/Package A or HCBS benefits until their waiver liability is met for the month. For this reason, providers must listen for waiver liability information on the IVR or, in the Portal, click on a benefit plan in the Coverage column of the eligibility verification information (Figure 1) to view coverage details (Figure 2), including the Waiver Liability Details panel (Figure 3), which shows the monthly waiver obligation and the member's balance that remains due for the month. Until the monthly obligation has been met, neither Full Medicaid/Package A nor HCBS waiver services are reimbursable by the IHCP.

Figure 3 – Waiver Liability Details Panel in the Portal Coverage Details

Waiver Liability Details

These amounts are based on claims processed at the time of this eligibility verification. It is subject to change at any time following this eligibility verification as claims continue to process in the system. A provider may bill a member for the Waiver Liability amount deducted from the adjudicated claim; however, with the exception of point of sale (POS) pharmacy claims, the member is not required to pay the provider until the member receives the monthly Medicaid Waiver Liability Summary Notice listing the amount applied to Waiver Liability.

Month	Waiver Liability Obligation	Waiver Liability Balance
March, 2014	$100.00	$76.37

Authorized Services

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

Eligibility Verification for 1915(i) HCBS Benefits

Members must be enrolled in the FFS Traditional Medicaid program, *Healthy Indiana Plan (HIP) State Plan – Plus*, *HIP State Plan – Basic*, 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

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.

Authorized Services

To view specific services that have been authorized for the member's 1915(i) HCBS benefit plan in the Portal, click the 1915(i) HCBS benefit plan name in the member's eligibility verification results to view the Detail Information panel for that coverage.

Figure 4 – Detail Information Panel for an AMHH Benefit Plan

Detail Information

Total Records: 2

Provider	Code	Description	Start Date	End Date	Units Authorized	Units Used	Amount Authorized	Amount Used
XXXXXXXX	H0034 UB	MED TRNG & SUPPORT PER 15MIN	10/15/2016	10/10/2017	728	-	-	-
XXXXXXX	H2014 UB	SKILLS TRAIN AND DEV, 15 MIN	10/15/2016	10/10/2017	2920	43	-	$601.22

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 approved to deliver the service
- **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 submitted for reimbursement prior to this date are not considered
- **End Date** – The end date of the service approval; services submitted for reimbursement after this date are not considered
- **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 Provider Healthcare Portal, the 837P electronic transaction, or the *CMS-1500* claim form. Hewlett Packard Enterprise 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.

Units of Service

If a unit of service equals 15 minutes, *a minimum of eight minutes* must be provided to bill for one unit. Activities requiring less than eight 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 eight minutes may be rounded up and billed as one unit. *Partial units totaling less than eight 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 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 an HCBS waiver claim, payment may be made to the wrong service provider.*

Example: A provider performs both 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

1915(i) HCBS providers are considered typical providers and must bill claims using the NPI.

CMS-1500 Claim Form Completion for 1915(c) HCBS Waiver Services

The following table lists the required fields for billing HCBS waiver services on the *CMS-1500* claim form. The table provides instructions for each required field. A copy of the *CMS-1500* claim form follows the table.

> *Note: For 1915(i) HCBS claims, including claims for AMHH, BPHC, and CMHW services, follow the general CMS-1500 instructions provided in the Claim Submission and Processing module.*

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*.

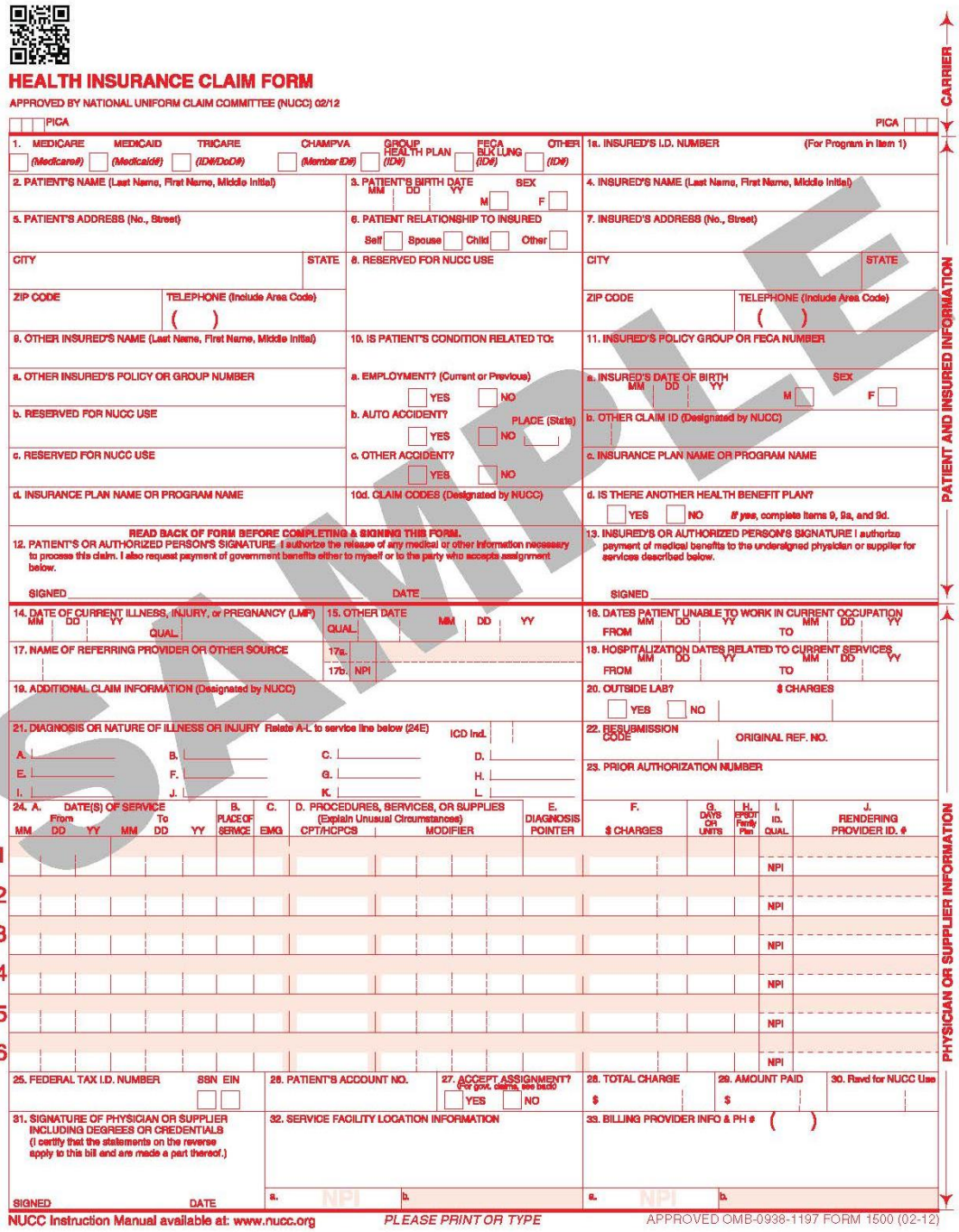
> *Note: The IHCP strongly advises providers to complete only the designated fields in Table 1 for an HCBS waiver. Completing optional fields could result in claim denial.*

Table 1 – *CMS-1500* Claim Form Fields for HCBS Waiver Claims

Form Field	Description	Instructions
1	TYPE OF INSURANCE COVERAGE	Enter **X** in the Medicaid box.
1a	INSURED'S I.D. NUMBER	Enter the 12-digit IHCP Member ID (also known as RID).
2	PATIENT'S NAME	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).
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Enter the name of the waiver case manager, *not* a physician's name.
17a	[ID NUMBER OF REFERRING PROVIDER OR OTHER SOURCE]	Enter the case manager's Provider ID, along with qualifier **1D** or **G2**. This number is listed on the member's NOA.
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	• Enter **R69** (for ICD-10) 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
24D	PROCEDURES, SERVICES, OR SUPPLIES	Use *only* 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 the R69 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.

Form Field	Description	Instructions
24I Top Half – Shaded Area	ID QUAL	Enter qualifier **1D** or **G2** in this field.
24J Top Half – Shaded Area	RENDERING PROVIDER ID #	Enter the rendering Provider ID. 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 Hewlett Packard Enterprise. • For all group providers, the rendering Provider ID is the agency's rendering number issued by Hewlett Packard Enterprise. The rendering Provider ID must be linked to the group number in *Core*MMIS. • For all sole proprietors or billing providers, the rendering Provider ID is the waiver Provider ID.
24J Bottom Half	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.*

Figure 5 – Paper *CMS-1500* Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Providers should submit the completed *CMS-1500* claim form, along with any additional required documentation, to Hewlett Packard Enterprise at the following address:

HPE 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

Providers are required to verify the specifications for documentation standards for all HCBS benefit plans the provider is authorized to operate. See the HCBS modules on the *Provider Reference Materials* page at indianamedicaid.com 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 *Contact Us* page at indianamedicaid.com.

When using the Portal to verify eligibility, hospice and LTC level of care information appears in the Nursing Home/Hospice Level of Care detail panel in the coverage details for the Full Medicaid or Package A benefit plan. See Figure 6.

Figure 6 – Nursing Home/Hospice Level of Care Coverage Details

Nursing Home / Hospice Level of Care		
Level of Care	**Effective Date**	**End Date**
Hospice Program	11/19/2013	12/31/2014
MR/DD Specialized Skilled Care in NF	12/01/2013	05/31/2014
Patient Liability/Client Obligation: $1,200.00		

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.

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 billing practice includes modifiers specific to claims for the following benefit plans:

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

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. 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 respective DA, DDRS, and DMHA provider modules as well as the *Indiana Statewide Transition Plan*:

- *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 Psychiatric Residential Treatment Facility Transition Waiver*
- *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*