INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Home Health Services

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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 April 1, 2016 Published: July 12, 2016	Semiannual update: • Updated documentation requirements in the *Home Health PA Documentation* section • Updated *Table 1 – Revenue Codes Crosswalked to Procedure Codes for Home Health Services* • Updated the *Home Health Reimbursement* section • Updated *Table 3 – Codes for Billing Initial Evaluations for Physical, Occupational, and Speech Therapy in Home Settings* • Removed references to home tocolytic infusion therapy and to code S9349 from the *Home Infusion and Enteral Therapy Services* section.	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 Published: August 16, 2016	Corrected the following tables: • *Table 1 – Revenue Codes Crosswalked to Procedure Codes for Home Health* • *Table 3 – Codes for Billing Initial Evaluations for Physical, Occupational, and Speech Therapy in Home Setting*	FSSA and HPE
1.3	Policies and procedures as of April 1, 2016 Published: January 5, 2017	Corrected the following table: • Restored revenue codes 441, 442, and 443 to *Table 1 – Revenue Codes Crosswalked to Procedure Codes for Home Health*	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
1.4	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: March 28, 2017	• Updated billing and PA instructions to include Provider Healthcare Portal options • Replaced references to Indiana*AIM* with *Core*MMIS • Clarified the use of 99600 TD in *Home Health Nursing PA Request Coding* • Updated billing information regarding occurrence codes in the *PA Exception for Hospital Discharge*, *Overhead Rate*, and *Home Health Reimbursement* sections • Added notes to *Table 1 – Revenue Codes Crosswalked to Procedure Codes for Home Health Services* and *Table 3 – Codes for Billing Initial Evaluations for Physical, Occupational, and Speech Therapy in Home Settings* to indicate code changes that took place after this module's effective date • Removed outdated home health agency rate-setting methodology from the *Home Health Reimbursement* section • Updated the Customer Assistance telephone number • Updated the CMCS mailing address	FSSA and HPE

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Note:	*For policy information regarding coverage of home health services, see the Medical Policy Manual at indianamedicaid.com.*

Introduction

Home health services are available to Indiana Health Coverage Programs (IHCP) members medically confined to the home, when services are ordered in writing from a physician and performed in accordance with the written plan of care. It is important to note that there is a distinction between the Medicare home health definition of "homebound" and Indiana Medicaid's definition of "homebound."

The Medicaid program serves a more expansive age range than the Medicare program. Under the Medicaid program, home health services may be provided to those who are medically confined to the home, including IHCP members who, because of illness or injury, are unable to leave home without the assistance of another person or an assistive device, or for whom leaving home is contrary to medical advice. Medicaid members who require the assistance of another person or assistive device, such as a wheelchair or walker, to leave the house to work or attend school may receive home health services. Home health services can be provided if medically necessary to assist in these day-to-day functions.

The following sections provide specific IHCP prior authorization, coverage, billing, and reimbursement procedures for home health services.

Home Health Prior Authorization Policies

All home health services require prior authorization (PA), except services ordered in writing by a physician before the member's discharge from a hospital, and that do not exceed 120 hours within 30 days of discharge. These limits refer to services provided by a registered nurse (RN), licensed practical nurse (LPN), and home health aide. Therapies such as occupational, physical, and speech are limited to 30 units of service within 30 days of an inpatient discharge from a hospital. The hospital discharge date is counted as day one.

A request to increase home health services, except in the case of urgent or emergency services, requires a written request with supporting documentation of medical necessity.

Home Health PA Documentation

An authorized representative of the home health agency (HHA) submits PA requests for home health agency services. See the *Prior Authorization* module for information about completing the *Indiana Health Coverage Programs Prior Authorization Request Form*, which is available on the *Forms* page at indianamedicaid.com. See the *Provider Healthcare Portal* module for information about submitting a PA request online via the Provider Healthcare Portal (Portal).

In addition to the PA request itself, the following information must be submitted:

- Copy of the written plan of treatment, signed by the attending physician, current through date of request
- Estimate of costs for the required services as ordered by the physician and set out in the written plan of treatment
  - The cost estimate must be provided on or with the plan of treatment and signed by the attending physician.
  - The estimate must reflect the cost of each service requested, plus the overhead rate for the time periods requested, as reflected on the plan of treatment.
- Number and availability of nonpaid caregivers that assist in member care (even when the number is zero)
- Number of members receiving home health services in a single household, so that care can be coordinated to use services in the most efficient manner
- Number of hours of service per day, number of visits per day, and number of days per week the service is to be provided
- Documentation of whether the member works or attends school outside the home, including what assistance is required
- Number of hours per day and number of days per week member receives of other non-IHCP home health services, including (not limited to) the following:
  - Medicare
  - Community and Home Option to Institutional Care for the Elderly and Disabled (CHOICE) program
  - IHCP waiver programs
  - Private insurance
  - Private pay
  - School systems
  - Any other paid caregivers

Effective June 1, 2015, the IHCP amended its electronic signature policy to allow electronic signatures on supporting documents, including physician orders and plans of treatment, submitted with PA requests for home health and hospice services. An original signature or signature stamp is still required on the *Indiana Health Coverage Programs Prior Authorization Request Form,* as well as on all State forms submitted as attachments to the request.

For general information about requesting PA, see the *Prior Authorization* module. For specific PA criteria for home health services, see *Indiana Administrative Code 405 IAC 5-16*.

PA for Home Health Nursing Services

Specific criteria pertaining to PA for nursing services can be found in *405 IAC 5-22-2*. The following PA requirements should be used as a guideline for determining procedures requiring PA, but the *IAC* is the primary reference.

IHCP reimbursement is available for intermittent or part-time nursing provided in the home by home health nurse services. PA is required for all nursing services rendered by RNs, LPNs, and home health aides from agencies that are IHCP providers. The exceptions are services ordered in writing by a physician before the member's discharge from an inpatient hospital. These services may continue for a period not to exceed 120 hours within 30 days of discharge.

PA includes consideration of the following information:

- Prescribed or ordered in writing by a physician
- Provided in accordance with a written plan of treatment developed by the attending physician
- Intermittent or part-time, except for ventilator-dependent members with a developed plan of home healthcare
- Deemed medically reasonable and necessary
- Deemed less expensive than any alternate mode of care
- Provided to a member at his or her place of residence, per *405 IAC 1-4.2-2*

> *Note: A member may work or attend school outside the home and still receive IHCP home health services. The PA request must specify the assistance needed to complete these outside activities.*

- Physical therapy, occupational therapy, and respiratory therapy ordered in writing by a physician to treat an acute medical condition, except as required in *405 IAC 5-22-8*, *405 IAC 5-22-10*, and *405 IAC 5-22-11*
- Written evidence of physical involvement and personal member evaluation is required to document the acute medical needs. A current plan of treatment and progress notes about the necessity and effectiveness of therapy must be attached to the PA request, and a copy must be available for post-payment audit.

Members are accepted for care on the basis of a reasonable expectation that the agency can adequately meet the member's health needs in the member's residence.

Medical Plan of Care

Medical care must follow a written medical plan of care established and periodically reviewed by the physician or attending physician as follows:

(1) The medical plan of care shall be developed in consultation with the agency staff and in consideration of all pertinent diagnoses, including the following:

(A) Mental status
(B) Types of services and equipment required
(C) Frequency of visits
(D) Prognosis
(E) Rehabilitation potential
(F) Functional limitations
(G) Activities permitted
(H) Nutritional requirements
(I) Medications and treatments
(J) Safety measures to protect against injury
(K) Instructions for timely discharge or referral
(L) Other appropriate items

Orders for therapy services include the specific procedures and modalities to be used, and the amount, frequency, and duration of each. The therapist and other agency personnel participate in developing the medical plan of care.

(2) The total medical plan of care must be reviewed by the physician or attending physician and home health agency personnel as often as the severity of the member's condition requires, but at least once every two months. Agency healthcare professional staff must promptly alert the person responsible for the medical component of the member's care to any changes that suggest a need to alter the medical plan of care. A written summary for each member must be sent to the physician or attending physician at least every two months.

When an existing plan of care overlaps a new prior authorization request, the clinical summary portion of the prior authorization request should be updated to reflect any change in the member's status. For example, if the plan of care covers a period from March 15 to May 15, and the new prior authorization request is from April 20 to October 20, the plan of care period overlaps the requested prior authorization period; therefore, the clinical summary portion of the prior authorization request should be updated to reflect any change in the member's status.

An *encounter* is a direct personal contact between a member and the person authorized by the home health agency to furnish services to the member. The *frequency of visits* is the number of encounters in a given period between a member and the person authorized by the home health agency to furnish services to the member. Frequency of visits may be expressed as a number or range. The number of encounters must be at least one.

To meet Indiana State Department of Health (ISDH) and PA guidelines, the specific frequency and duration must be on the signed plan of care and the prior authorization request, as given in the following example: A skilled nurse is required for wound care setup, two hours per day, Monday through Friday, for nine weeks.

A similar federal regulation is cited at *Code of Federal Regulations 42 CFR 484.18(a)*:

(a) Standard: Plan of Care: The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel participate in developing the plan of care.

Home Health Nursing PA Request Coding

The IHCP ***only*** issues PA for home health nursing based on procedure code 99600 TD – *Unlisted home visit, service, or procedure – registered nurse*. PA requests for home nursing do not need to indicate whether an RN or an LPN is to perform the service, because that level of detail is reported on the claim.

Home health providers can bill 99600 TE – *Unlisted home visit or service – LPN/LVN* or 99600 TD – *Unlisted home visit, service, or procedure – registered nurse*, and the IHCP Core Medicaid Management Information System (*Core*MMIS) uses the approved PA units for the RN service 99600 TD.

PA Exception for Hospital Discharge

Providers can perform certain home health services without PA following IHCP member discharge from a hospital, if the parameters meet those outlined in the *Indiana Administrative Code (IAC)*. Within the constraints in several IAC rules, the following apply:

- Providers may perform home health services without PA when an RN, LPN, or home health aide performs the service, if the service does not exceed 120 units within 30 calendar days following hospital discharge.
  - The physician must order services in writing prior to the patient's hospital discharge.
  - The patient must be homebound.
- Any combination of therapy services ordered in writing by a physician cannot continue beyond 30 units in 30 calendar days without PA.
  - The physician must order services in writing prior to the patient's hospital discharge.
  - The patient must be homebound.
- Services must be within the limits specified in *405 IAC 5-16-3*.
- For dates of service on or after February 13, 2017, providers should use occurrence code 42 with the corresponding date of discharge in the occurrence code and occurrence date fields of the claim (fields 31a–34b on the *UB-04* claim form) to bypass PA requirements associated with the preceding parameters. For dates of service before February 13, 2017, providers should use occurrence code 50 with the corresponding date of discharge.

When a provider bills for services exceeding the limitations established in the IAC, and the provider has not received PA for additional units, *Core*MMIS automatically denies or cuts back units on the RA.

The IHCP does not require PA for an emergency visit, but providers must request a Prior Authorization System Update from the PA Department to continue service provision.

Home Health Billing Procedures

Home health providers follow the general billing directions for completing the *UB-04* claim form or electronic equivalent (837I transaction or Portal institutional claim), as described in the *Claim Submission and Processing* module, with the exception of the service date, local codes, and the additional type of bill codes. In the *HCPCS/Rates* field (field 44 of the *UB-04* claim form), providers must enter the Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT®[1]) code for the service provided, not the rate. Table 1 lists revenue codes and the crosswalked HCPCS/CPT codes.

[1] *CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Table 1 – Revenue Codes Crosswalked to Procedure Codes for Home Health Services

Revenue Code	Procedure Code	Revenue Code	Procedure Code
420	G0151	440	G0153
421	G0151	441	G0153
422	G0151	442	G0153
423	G0151	443	G0153
424	97001*	444	92521–92524
429	G0151	449	G0153
430	G0152	552	99600 TD
431	G0152	552	99600 TE
432	G0152	559	S9349***
433	G0152	559	99601, 99602
434	97003**	572	99600
439	G0152		

* *97001 was end-dated on December 31, 2016. Effective January 1, 2017, this code was replaced by 97161, 97162, and 97163.*

** *97003 was end-dated on December 31, 2016. Effective January 1, 2017, this code was replaced by 97165, 97166, and 97167.*

*** *S9349 is noncovered by the IHCP effective March 16, 2016.*

Submit home health claims electronically or mail them to the following address for processing:

HPE Home Health Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

Note: For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, bill the appropriate managed care entity (MCE). Contact information can be found in the IHCP Quick Reference Guide at indianamedicaid.com.

Unit of Service

Each line item identifies services billed using HCPCS codes and service dates. Providers must bill each date of service as a separate line item and bill each level of service, such as RN or LPN, provided on the same date as a separate line item. The procedure code description defines the unit of service. When home health providers perform the same service, such as multiple RN visits on the same date of service, they must bill those services on the same claim form and on one detail with the total number of units of services provided. Billing separate lines for the same service with the same date of service causes claims to be denied as exact duplicates. The Family and Social Services Administration (FSSA) sets the rate for each procedure code.

The billing units of home health visits for therapists, home health aides, LPNs, and RNs are as follows:

- For therapy visits – Therapy codes are measured as one unit equals 15 minutes. If the therapist is in the home eight minutes or more, the provider can round the visit up to the 15-minute unit of service. If the therapist is in the home for seven minutes or less, the provider cannot round this up and, therefore, cannot bill for it.
- For home health aides, LPN, or RN visits – Nursing services are measured as one unit equals one hour. If the home health aide, LPN, or RN is in the home for fewer than 29 minutes, providers can bill for the entire first hour only if they provided a service. For subsequent hours in the home, providers should round up any partial unit of service of 30 minutes or more to the next highest unit, and round down any partial unit of service of 29 minutes or less to the next lowest unit. (For example, 85 minutes spent on billable patient care activities is rounded down to one unit, and 95 minutes spent on billable patient care activities is rounded up to two units.)

If the therapist, home health aide, LPN, or RN enters the home and the member refuses service, providers cannot bill for any unit of service. Overheads are linked with reimbursement for services provided. When the provider does not render a service, the IHCP does not reimburse the provider for overhead.

Overhead Rate

Providers may report only one overhead per provider, per member, per day. Providers use the appropriate occurrence code and corresponding dates to indicate the appropriate overhead fee for a claim. Providers must bill home health overhead with occurrence code 73 for dates of service on or after February 13, 2017. For earlier dates of service, use occurrence code 61.

Occurrence code 73 (or 61 for dates of service before February 13, 2017) indicates that one encounter with the member occurred on the date shown: Providers should use the following guidance when billing the overhead occurrence code for nonconsecutive and consecutive dates of service on the *UB-04* claim form or Portal institutional claim:

- If the dates of service billed are not consecutive:
  - On the *UB-04* claim form, for each nonconsecutive date of service billed, providers should enter the occurrence code and the corresponding date in the Occurrence Code and Date fields (31a–34b).
  - On the Portal institutional claim, for each nonconsecutive date of service billed, in the Occurrence Codes panel, providers should enter the occurrence code and the corresponding date, using the same date in both the From Date and To Date fields for each entry.
- If the dates of service billed are consecutive, and one encounter was provided every day:
  - On the *UB-04* claim form, providers should enter the appropriate occurrence code and the first and last dates of service being billed in the Occurrence Span Code, From, and Through fields (35a–36b).
  - On the Portal institutional claim, use the same occurrence code fields as are used for nonconsecutive dates, but use the From Date and To Date fields to indicate that the single code entry represents a span.

Note:	*Providers cannot bill overhead for an occurrence span that includes dates of service before February 13, 2017, in combination with dates of service on or after February 13, 2017; overhead for these encounters must be billed separately with the appropriate occurrence code (61 or 73).*

Providers that submit more than one claim in a multiple-member care situation should attach the overhead to only one of the submitted claims. As long as the overhead is attached to only one member, it does not matter to which member it is attached.

Note:	*Providers should not add the dollar figures associated with the overhead rates to the claim when calculating total charges. The Remittance Advice (RA) or 835 transaction automatically reflects the appropriate overhead amounts.*

Multiple-Visit Billing

When providers make multiple visits for the same prior-authorized service to a member during one day, providers should bill all visits on the same claim form and on one detail with the total number of units of service provided. If providers bill these services on separate claim forms or on separate claim details, the IHCP denies one or more of the services as a duplicate service.

If additional hours of the same service are identified after a claim has been adjudicated and paid, providers must submit a paid claim adjustment. Procedures for submitting a paid claim adjustment are in the *Claim Adjustments* module.

Home health agency providers should be aware that rotating personnel in the home merely to increase billing is not appropriate.

Example: A home health agency sent an RN to a member's home in the morning and an LPN to the same home in the evening of July 15, 2015. The first nurse performed two hours of RN services in the morning, and the second nurse performed two hours of LPN services in the evening of July 15, 2015.

Detail 1: Revenue Code 552 with HCPCS 99600 TD. The date of service is 7/15/15 and the unit of service is 2.

Detail 2: Revenue Code 552 with HCPCS 99600 TE. The date of service is 7/15/15 and the unit of service is 2.

Home Health Reimbursement

Effective for *from* dates of service of January 1, 2014, through June 30, 2017, the IHCP implemented a 3% reimbursement reduction for home health services, as indicated on the Fee Schedule.

Table 2 – Home Health Services

Code	Service Performed By	Billing Unit
No Code	Overhead	One unit per provider per recipient per day
99600 TD	Registered nurse	Hourly
99600 TE	Licensed practical nurse	Hourly
99600	Home health aide	Hourly
G0151	Physical therapist	15-minute increments
G0152	Occupational therapist	15-minute increments
G0153	Speech pathologist	15-minute increments

Pursuant to *405 IAC 1-4.2*, home health providers are reimbursed for covered and prior-authorized services provided to IHCP members through standard, statewide rates computed by adding the following:

- Overhead cost rate
- Staffing cost rate multiplied by the number of hours spent performing billable patient care activities

Reimbursement is limited to one overhead per day, using occurrence code 73 for dates of service on or after February 13, 2017 (occurrence code 61 for earlier dates of service). See the Fee Schedule at indianamedicaid.com for coverage, billing, and rate information.

Providers can obtain the current wage rate from Customer Assistance toll-free at 1-800-457-4584. Providers can also visit the *Bulletin Search* page at indianamedicaid.com, and search by keywords "home health" for the most current publication containing home health rates.

Registered Nurse Delegation to Home Health Aides

The IHCP has specific guidelines for tasks that are to be performed by RNs versus those performed by home health aides. Providers are expected to staff according to these guidelines. The *IHCP Provider Agreement* specifies that providers follow all applicable federal and state regulations in addition to the policies and procedures outlined in the *IHCP Provider Reference Modules*, bulletins, and banner pages, all available at indianamedicaid.com. Note that the IHCP periodically amends its policies and procedures. It is the provider's responsibility to use the most up-to-date information. For federal and state regulations, see *42 CFR 484.36* and *410 IAC 17-14-1(g)-(n)*.

The following services are not covered except as specified under applicable IHCP waiver programs:

- Transporting the member to grocery stores, pharmacies, banks, and so forth
- Homemaker services
- Chores (including running errands)
- Sitter or companion services
- Respite care

The IHCP may grant PA for skilled services under the home health benefit; however, the HHA must bill the IHCP for services that were provided as follows: **The skilled nurse renders home health aide services because the agency was unable to contract a home health aide.**

The agency must then document that the nurse rendered the home health aide service. The agency must bill the IHCP using the appropriate code for home health aide services. If the post-payment review identifies that the agency billed for skilled nursing services rather than for home health aide services, the IHCP recoups the overpayment.

Initial Evaluations for Physical, Occupational, and Speech Therapy in Home Settings

Home health providers should use the CPT procedure code and corresponding revenue code listed in the following table, as appropriate, when billing for initial evaluations for physical, occupational, or speech therapy in home settings. PA is not required for initial evaluations.

Table 3 – Codes for Billing Initial Evaluations for
Physical, Occupational, and Speech Therapy in Home Settings

Therapy Service	Procedure Code and Description	Revenue Code and Description
Physical	97001* – *Physical therapy evaluation*	424 – *Evaluation or re-evaluation* (for physical therapy)
Occupational	97003** – *Occupational therapy evaluation*	434 – *Evaluation or re-evaluation* (for occupational therapy)
Speech	92521 – *Evaluation of speech fluency (eg, stuttering, cluttering)*	444 – *Evaluation or re-evaluation* (for speech therapy)
Speech	92522 – *Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)*	444 – *Evaluation or re-evaluation* (for speech therapy)
Speech	92523 – *Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)*	444 – *Evaluation or re-evaluation* (for speech therapy)
Speech	92524 – *Behavioral and qualitative analysis of voice and resonance*	444 – *Evaluation or re-evaluation* (for speech therapy)

* *97001 was end-dated on December 31, 2016. Effective January 1, 2017, this code was replaced by 97161, 97162, and 97163.*

** *97003 was end-dated on December 31, 2016. Effective January 1, 2017, this code was replaced by 97165, 97166, and 97167.*

Telehealth Services

Effective October 1, 2014, the IHCP covers telehealth services provided by home health agencies. See the *Telemedicine and Telehealth Services* module for more information.

Home Infusion and Enteral Therapy Services

Home infusion includes the following:

- Enteral feeding within, or by way of, the intestine
- Enteral tube feeding that includes the provision of nutritional requirements through a tube into the stomach or small intestine
- Parenteral therapy that includes any route other than the alimentary canal, such as intravenous, subcutaneous, intramuscular, or mucosal
- Total parenteral nutrition therapy (TPN)

Billing for Home Infusion and Enteral Therapy

The following provider types may bill for home infusion and enteral therapy services and supplies:

- DME and home medical equipment (HME) providers
- Home health agencies (HHAs)
- Pharmacies

Providers should bill separately for the following three components of home infusion and enteral therapy:

- DME and HME providers bill all supplies, equipment, and formulas required to administer home infusion and enteral therapy on a *CMS-1500* claim form or electronic equivalent (Portal professional claim or 837P transaction) using the appropriate HCPCS code.
- HHAs bill only for services provided in the home by an RN or LPN on the *UB-04* claim form or electronic equivalent using the appropriate HCPCS codes.
- Pharmacies bill for compound drugs or any drugs used in parenteral therapy on an *Indiana FSSA Drug Claim Form* or electronic equivalent using the appropriate National Drug Code (NDC).

HHAs may bill all three components using the proper billing forms and appropriate codes if the HHA maintains multiple enrollments as an HHA, Pharmacy and DME, or HME provider.

Home Uterine Monitoring Device

Codes 99601 and 99602 cover the following items:

- Home uterine monitor
- Skilled nursing services that include the following:
  - Initial nursing assessment
  - Instructions given to the patient about the proper use of the monitor
  - Home visits to monitor signs and symptoms of preterm labor
  - Twenty-four hour telephone support for troubleshooting the monitoring equipment and for reporting patient symptoms

Any costs involved in transmitting reports to the physician electronically, such as fax or telephone modem, are included in the payment.

Providers can contact Cooperative Managed Care Services (CMCS) to request PA:

Cooperative Managed Care Services
Prior Authorization Department
P.O. Box 56017
Indianapolis, IN 46256

Toll-Free Telephone: 1-800-269-5720
Fax: 1-800-689-2759

Note:	*For Healthy Indiana Plan, Hoosier Care Connect, and Hoosier Healthwise members, contact the appropriate MCE to obtain PA. The contact information can be found in the IHCP Quick Reference Guide at indianamedicaid.com.*

HHAs can bill for 99601 and 99602 using standard home healthcare billing guidelines. All supplies for each therapy are bundled into a daily rate, and HHAs are not allowed to bill separately for any supplies associated with these therapies. HHAs are also not allowed to bill an overhead charge when daily infusion services do not include an actual encounter in the home.

Providers are allowed to bill one unit of service daily and should use revenue code 559 when billing 99601 and 99602.