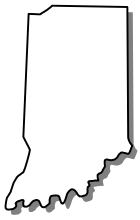
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

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To: **All Home and Community-Based Services Waiver Providers, All Waiver Case Management Services Providers, and All Targeted Case Management Services Providers**

Subject: **Respite Care Services, Spenddown, CHOICE, and Rounding of Units**

Overview

The purpose of this bulletin is to inform Home and Community-Based Services (HCBS) waiver providers, all entities providing waiver case management services and all entities providing targeted case management services of the requirements for authorizing and approving respite care services for waiver members; submission of claims for waiver members having spenddown; requirements for authorizing and approving *Community and Home Options to Institutional Care for the Elderly (CHOICE);* and the approved method of rounding units of services provided to waiver members.

EDS, the contracted fiscal agent for the Indiana Family and Social Services Administration (IFSSA), reimburses services according to the Indiana Health Coverage Programs (IHCP) criteria as outlined in *405 IAC 1-5-1*. As part of the requirements for the HCBS waivers, the Office of Medicaid Policy and Planning (OMPP) established a review process for the HCBS waiver programs. During these reviews, EDS review teams have identified numerous issues concerning respite, spenddown, CHOICE, and appropriate billing practices.

Respite Care Services

"Respite care services means services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absences or need for relief of those persons normally providing care." (*460 IAC 6-3-50)* **Respite care is provided so that the primary caregiver(s) can take a break from the daily routine of care giving.** It is not required that the member be living with the primary caregiver(s). However, members living alone must be receiving on-going and regularly scheduled care from family members, friends, or neighbors to have respite services added to a plan of care (POC). Respite care is to give the caregiver(s) temporary relief from stress experienced while providing extra care for the member. Respite care enables family members to take vacations, run errands, or have a few hours of time off. Respite care services under the HCBS waiver programs cannot be authorized as a substitute for child or daycare. If there are other children or family members in the household who require supervision, the respite caregiver cannot provide this additional supervision, and respite care cannot be authorized for a caregiver to go to work.

As with all waiver services the respite care services must be included in the individual's plan of care (POC). It may be possible to predetermine when the individual will want to use the respite care benefit. However, the nature of respite service requires the hours to be flexible. Case managers must be aware of this need and modify POCs to accommodate required changes.

The level of professional care provided under respite care services depends on the needs of the individual receiving respite services. An individual requiring assistance with bathing; meal preparation and planning; specialized feeding, such as an individual who has difficulty swallowing, refuses to eat, or does not eat enough; dressing or undressing; hair and oral care; and weight bearing transfer assistance should be considered for respite home health aide or respite attendant care services.

An individual requiring infusion therapy; venipuncture; injection; oral medication; hoyer lift; wound care for surgical, decubitus, incision, and so forth; ostomy care; and tube feedings should be considered for respite nursing services.

An individual requiring assistance with light housekeeping, laundry, meal preparation, shopping or errands, companionship, and general supervision, but not requiring hands-on care, should be considered for respite homemaker services.

Documentation of services must clearly indicate that respite care services were provided. In addition, a provider of respite care services must maintain chronological documentation of the services provided for an individual. The documentation should include the date and duration of respite care services provided, the signature of the person providing respite care services and the location or setting where the services were provided.

Spenddown

Some members with income in excess of the traditional IHCP threshold can still be enrolled in the program. These members are enrolled in Traditional Medicaid with a spenddown. Spenddown is similar to a deductible in that members must incur medical expenses in the amount of their excess income each month before becoming eligible for Traditional Medicaid. It is the member's responsibility to provide verification of incurred medical expenses to the local Office of Family and Children. When spenddown is met, the member becomes eligible for the remainder of the month.

To understand the claims processing requirements for spenddown members, providers must determine which of the following scenarios applies in relation to the date of service:

- The date of service is prior to the date spenddown was met.
- The date of service is the same as the date spenddown was met.
- The date of service is after the date spenddown was met.

If the date of service is prior to the date spenddown was met, **the service is not reimbursable by the IHCP.** In these situations, the provider collects payment for the service from the member or bills the member if payment is not collected from the member on the date of service.

A provider that renders service to a member **on the date spenddown was met** must attach a form *DPW 8A* to the claim to receive payment. The *DPW 8A*, *Notice to Provider of Recipient Deductibility*, is obtained from the local Office of Family and Children and is intended to notify the provider of the need to apply a deductible to the claim. The deductible is the portion of the provider's charge applied toward satisfying the member's spenddown liability on the date spenddown was met**. This deductible amount is not reimbursable by the IHCP on the date spenddown was met and must be collected from the member or be billed to the member.**

For electronic billing, the *DPW 8A* cannot be sent with the claim when filed. If the service is rendered on the date spenddown is met, a claim correction form (CCF) is generated and sent to the provider. The provider can attach the *DPW 8A* to the CCF and return the document to EDS for processing. When the date of service is after the date spenddown was met, no *DPW 8A* is required. The provider can submit the claim to the IHCP in the same manner as a non-spenddown member.

Spenddown Example

In this example, an individual's spenddown amount is $500. Residential Habilitation and Support Daily Rate (Z5178) services are provided each day of the month at $175 per day.

- December 1, 2002 – Residential Habilitation and Support Daily Rate (Z5178) is provided at a cost of $175. The provider collects $175 from the member.
- December 2, 2002 – Residential Habilitation and Support Daily Rate (Z5178) is provided at a cost of $175. The provider collects $175 from the member.
- December 3, 2002 – Residential Habilitation and Support Daily Rate (Z5178) is provided at cost of $175. The provider or member furnishes a statement to DFC indicating the total charges for the three days. An *8A* is issued from DFC with a deductible amount of $150. DFC calculates this deductible amount by subtracting the charges of $350 from December 1 and December 2 from the $500 spenddown amount. The provider collects the deductible amount of $150 plus the December 1 and December 2 charges of $350 from the member.

The provider must submit a Centers for Medicaid and Medicare Services (CMS) HCFA-1500 claim form with the *DPW Form 8A* for reimbursement of services rendered from the date spenddown was met to the final day of the month that services were provided. Include on the claim only the dates of service, units, and dollar amount for those dates of service **from the day the spenddown was met until the final day of the month that services were provided.**

In this example, 29 units at $175 per unit would be entered; the billed amount of $5,075 and dates of services would be December 3 through December 31, 2002. The IHCP reimbursement would include the remaining $25 for December 3, 2002. **Do not include dates of service, units, or dollar amounts for those days when spenddown was not met.**

Spenddown Summary

No program reimbursement is available for services rendered **prior** to the spenddown effective date. A member is eligible for services rendered **on** the spenddown effective date, depending on when the spenddown amount was satisfied. All providers of service must obtain a *DPW Form 8A*, even if the deductible was zero, for services rendered on the spenddown effective date. However, the member is responsible for paying the spenddown amount.

CHOICE

The FSSA implemented the CHOICE Program for persons with disabilities in 1992. The Area Agency on Aging (AAA) case management system provides the single point of entry into this program. This makes services accessible for individuals and families through a coordinated and integrated approach.

In-home services include home health services, homemaker, attendant care, respite care, adult daycare, transportation, home delivered meals, therapies, and other appropriate services such as minor home modifications and adaptive aids.

To be eligible for CHOICE Program services, an individual must be a resident of Indiana, age 60 years old or older; or be any age, have disabilities, and be unable to perform two or more activities of daily living as determined by an assessment using the Long Term Care Services Eligibility Screen. **Medical expenses paid by CHOICE can be used to meet the individual's IHCP spenddown.**

Rounding of Units of Service

Procedure codes specify the units for which a particular service can be billed. Units of service are billed in 15-minute, 30-minute, or 60-minute increments. For example, *Z5606 Respite/Attendant Care/Personal Assistance Services (1 hour = 1 unit)* is billed in one-hour units. Therefore, one hour of this rendered service is billed as one unit. Two hours of this rendered service are billed as two units and so on. Partial units of service cannot be billed. If a fractional unit of service is rendered, units of service shall be accrued to the end of the current month. At the end of the current month partial units can be rounded to the next whole unit when calculating reimbursement. When rounding of units occurs at the end of the billing month, the following guidelines can be used by providers :

- 15-minute units of service:
  - Any partial unit of service eight minutes or more is rounded up to a 15-minute unit of service.
  - Any partial unit of service seven minutes or less must not be rounded up and therefore should not be billed.
- 30-minute units of service:
  - Any partial unit of service 15 minutes or more is rounded up to a 30-minute unit of service.
  - Any partial unit of service 14 minutes or less must not be rounded up and therefore should not be billed
- 60-minute units of service:
  - Any partial unit of service 30 minutes or more is rounded up to a 60-minute unit of service.
  - Any partial unit of service 29 minutes or less must not be rounded up and therefore should not be billed

Additional Information

Direct questions about the information in this bulletin to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.