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 Waiver Providers, Extended Care ICF/MRs, and Rehabilitation Facilities

Subject: Traumatic Brain Injury Waiver Program

Overview

Beginning January 1, 2000, the Health Care Financing Administration (HCFA) has approved the Traumatic Brain Injury (TBI) Waiver for Indiana. The purpose of this bulletin is to provide information on the following topics:

- Provider enrollment
- Individual eligibility
- Approved services
- Appropriate procedure codes
- Basic billing procedures

Provider Enrollment

Providers interested in participating in the TBI Waiver Program should contact the Medicaid Waiver Unit to request an application. The Medicaid Waiver Unit will send an application to prospective providers to determine program eligibility. Providers should submit requests and return documents to the following address:

Medicaid Waiver Unit
Bureau of Aging and In-Home Services
Division of Disability, Aging and Rehabilitative Services
402 W. Washington Street, P.O. Box 7083, MS-21
Indianapolis, IN 46207-7083

The Medicaid Waiver Unit will review the request. If a provider is approved, the application will be forwarded to EDS for enrollment in the Indiana Health Coverage Programs (IHCP). Once EDS receives the application, a unique IHCP provider number will be assigned for the TBI Waiver Program.

> *Note: If a provider has an existing waiver provider number, only specialty 356 – TBI Waiver will be added to the current provider number. Also, if a provider is currently enrolled as a non-waiver provider in the IHCP, a new waiver provider number will be issued. Please review the basic billing procedures section of this bulletin for more information on the use of the number.*
>
> *Case Managers that would like to apply to become TBI Waiver Program providers should contact their local area on aging for information on becoming certified for TBI Waiver case management services.*

Upon completion of the enrollment process, EDS will send a confirmation letter with a provider number, service location, effective date of enrollment, and an *Indiana Medicaid Program Home and Community-Based Waiver Programs Provider Manual*. After a provider receives the confirmation letter and the *Indiana Medicaid Program Home and Community-Based Waiver Programs Provider Manual*, the provider can begin billing for TBI services.

Providers interested in applying for additional specialties in the Indiana Waiver Program should apply through the Indiana Waiver Program. All other provider file updates or changes to the waiver provider number need to be submitted in writing to the EDS Provider Enrollment Unit at the following address:

EDS
Provider Enrollment
P.O. Box 68420
Indianapolis, Indiana 46268-0420

Please submit updates and changes to the following address after April 1, 2000:

EDS
Provider Enrollment
P.O. Box 7263
Indianapolis, Indiana 46207-7263

In January 2000, EDS and the Medicaid Waiver Unit targeted certain approved waiver providers for temporary enrollment in the TBI Waiver Program. These providers were ICF/MR Waiver providers and case managers approved for the aged and disabled. These providers have eligibility to bill services for the TBI Waiver Program from January 1, 2000, to June 30, 2000.

Individual Eligibility for TBI

A TBI is defined as an injury to the brain arising from external forces, including closed or open head injuries, toxic chemical reactions, anoxia, near drowning, and focal brain injury. TBI does not include injuries that are vascular in origin (CVA or aneurysm), alcoholism, Alzheimer's Disease, or the infirmities of the aging. As a result of the traumatic brain injury, the individual demonstrates significant physical, cognitive, emotional, or behavioral impairments.

An individual's case manager must compile a level of care packet and prepare a plan of care/cost comparison budget for submission to the Medicaid Waiver Unit. The Office of Medicaid Policy and Planning (OMPP) must determine if the individual meets the criteria for the TBI Waiver Program and nursing facility level of care. The Medicaid Waiver Unit must determine if the plan of care is cost effective and a waiver opening is available. Upon approval, level of care information is loaded into the Indiana*AIM* system and provider claims can be reimbursed.

Approved TBI Services

The following services can be provided and billed for under the TBI Waiver Program:

- Case management
- Homemaker
- Personal care services
- Respite care services
- Habilitation that includes any of the following:
  - Independent living skills training
  - Structured day program
  - Prevocational services
  - Supported employment services
- Environmental modifications

- Specialized medical equipment and supplies
- Personal emergency response system
- Adult companion services
- Residential care or community residential services
- Extended State plan services, including any of the following:
  - Physical therapy services
  - Occupational therapy services
  - Speech, hearing, and language services
- Behavior programming/counseling and training

Table 1.1 – Billable Procedure Codes for TBI Services

Code	Description	Unit
X3008	Attendant care and personal assistance (IDDARL-ILS)	½ hour
X3011	Prevocational services	¼ hour
X3012	Supported employment	¼ hour
X3013	Adaptive aids, devices, or **special medical equipment** – **initial**	
X3014	Adaptive aids, devices, assist tech., **special medical equipment** – **maintenance**	
X3015	Occupational therapy (HHA)	¼ hour
X3016	Occupational therapy (IDDARS – HAB agency/other)	¼ hour
X3017	Physical therapy (HHA)	¼ hour
X3018	Physical therapy (IDDARS – HAB agency/other)	¼ hour
X3019	Environmental modifications – initial	
X3020	Environmental modifications – maintenance	
X3064	Res based habilitation and ADL training in independent living skills	¼ hour
Z5076	Personal care service (HHA)	1 hour
Z5077	Companion care	1 hour
Z5078	Respite – personal care service (HHA)	1 hour
Z5079	Respite – companion care	1 hour
Z5080	Case management (TBI)	¼ hour
Z5603	Homemaker (HHA/HSA)	1 hour
Z5604	Atten. care/personal assist./**res. care/ com. res. serv.** (HHA/HSA)	1 hour
Z5605	Respite – homemaker (HHA/HSA)	1 hour
Z5606	Respite/atten. care/personal assist./**res. care/com. res. serv.** (HHA/HSA)	1 hour
Z5607	Respite – home health aide (HHA)	1 hour
Z5608	Respite – LPN (HHA)	1 hour

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Table 1.1 – Billable Procedure Codes for TBI Services

Code	Description	Unit
Z5609	Respite – RN (HHA)	1 hour
Z5620	Personal emergency response system – monthly	
Z5652	Homemaker (non-agency)	1 hour
Z5653	Atten. care/personal assist./**res. care/com. res. serv.** (non-agency)	1 hour
Z5654	Respite – homemaker (non-agency)	1 hour
Z5655	Respite/atten. care/personal assist./**res. care/com. res. serv.** (non-agency)	1 hour
Z5699	Personal emergency response system – installation	
Z5708	Speech and language therapy (HHA)	¼ hour
Z5715	Speech and language therapy (IDDARLS-ILS/HAB agency or other)	¼ hour
Z5720	Respite/atten. care/personal assist./**res. care/comm. res. services** (IDDARS-ILS)	1 hour
Z5724	Day habilitation – **individual structured day programming**	¼ hour
Z5725	Day habilitation – **group structured day programming**	¼ hour
Z5726	Behavior management, behavior programming/counseling and training	¼ hour
Z5071	Specialized medical equipment and supplies (initial) manual pricing	
Z5072	Specialized medical equipment and supplies (maintenance) manual pricing	

Note: These codes are specific to the waiver provider type and specialty

Table 1.2 – Existing Procedure Codes

Code	Description	Units
Z5603 (agency)	Homemaker	1 hour
Z5652 (non-agency)	Homemaker	1 hour
X3011	Prevocational services	¼ hour
X3012	Supported employment	¼ hour
X3017	Physical therapy	¼ hour
X3015	Occupational therapy	¼ hour
Z5708	Speech and language therapy	¼ hour
Z5605 (agency)	Respite – homemaker	1 hour
Z5654 (non-agency)	Respite – homemaker	1 hour
Z5607	Respite – home health aide	1 hour

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Table 1.2 – Existing Procedure Codes

Code	Description	Units
Z5608	Respite – LPN	1 hour
Z5609	Respite – RN	1 hour
X3019 (manual pricing)	Environmental modifications – initial	
X3020 (manual pricing)	Environmental modifications – maintenance	
Z5699	Personal emergency response system – installation	
Z5620	Personal emergency response – monthly	

Basic Billing Procedures

The following format should be used in billing all waiver services rendered:

HCFA 1500 Claim Form Billing Instructions for Waiver Providers

Only the following boxes on the HCFA 1500 form are required for completion when submitting an IHCP waiver claim. Boxes that are not required are not listed.

It is important that providers only complete the required boxes when submitting a waiver claim. Completing information on the HCFA 1500 that is **not** required for a waiver claim can cause Indiana*AIM* to fail to recognize the claim as a waiver claim. Thus, the claim will be processed like a Traditional Medicaid Program claim and this can result in claim denial. Table 1.3 provides additional information on completing the HCFA 1500 for waiver claims.

Table 1.3 - HCFA 1500 Waiver Claims Instructions

Box Number	Description	Instructions
1	Type of Insurance Coverage	Check the **Medicaid** box.
1a	Insured's ID Number	Enter the 12-digit Patient Control Number (recipient identification or RID number) from the member's Hoosier Health Card.
2	Patient Name	Enter the patient's last name, first name, and middle initial, if any, as shown on the member's Hoosier Health Card.

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Table 1.3 - HCFA 1500 Waiver Claims Instructions

Box Number	Description	Instructions
3	Patient Birth Date and Sex	Enter the month, day, and year of member's birth in six-digit format (MM/DD/YY) and indicate if the member is male or female.
9a	Other Insured's Policy or Group Number	Enter **None**.
17	Name of Referring Physician or Other Source	Enter the name of the waiver case manager not a physician name.
17a	ID Number of Referring Physician or Other Source	Enter the case manager's identification number; this is the nine-digit number issued by EDS. Obtain this number from the member's waiver case manager. This number is also listed on the waiver member's plan of care.
21	Diagnosis or Nature of Illness or Injury	Enter **V709** on the first line to indicate the diagnosis code for all waiver members, regardless of actual diagnosis **Do not enter any other diagnosis code on a waiver claim.** Note: If billing electronically, box 21 must be completed. However, if billing on a paper claim form, box 21 can be left blank, with this exception: If a provider chooses to complete box 21 on a paper claim, the provider must also complete box 24e with 1.
24a	Date(s) of Service	Enter the month, day, and year for the **from** and **to** date applicable to the billing period for each service rendered. Use the six-digit, (MM/DD/YY) format. Always complete both the **from** and **to** dates even if service delivery was for only one day.
24b	Place of Service	Enter the appropriate two-digit code from the list below: 11 – Office/Clinic 12 – Home See the *(IHCP) Indiana Medicaid Program Home and Community-Based Waiver Programs Provider Manual* for a more complete list.
24d	Procedures, Services, or Supplies	Use only waiver service and procedure codes exactly as they are shown in the *(IHCP) Indiana Medicaid Program Home and Community-Based Waiver Programs Provider Manual* (currently found in the update pages dated March 24, 1997). Enter the procedure code on the left side of the section, under **CPT/HCPCS**. No modifier is used with any waiver procedure code.

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Table 1.3 - HCFA 1500 Waiver Claims Instructions

Box Number	Description	Instructions
24e	Diagnosis Code	Enter **1**, referring to the line in box 21 where the **V709** diagnosis code was entered. Do not enter the V709 diagnosis in box 24e again because this will cause the claim to deny. Note: For electronic billing, this is **required**. If billing on a paper claims form, box 24e can be left blank, with the following exception: If box 24e is completed on a paper claim, box 21 **must** also be completed with V709.
24f	Charges	Enter only the total charge for this service, based on the number of units billed in box 24g.
24g	Days or Units	Enter the total number of units, in whole units only, for the service date(s) on each line. The definition of what is a unit varies with the service. This information is listed in the *Indiana Medicaid Program Home and Community-Based Waiver Programs Provider Manual* with each service definition. Do not enter partial units. Partial units of .5 or larger should be rounded up to the next whole number (for example, 1.5 units will be billed as 2 units). Partial units less than .5 will be rounded down to the next whole number (for example, 1.3 units will be billed as 1 unit). Do not enter decimals. For example, 15 units should be entered as 15, not 15.0
24k	Reserved for Local Use	Enter the rendering provider number here. What the rendering number is depends on the type of provider billing. *For agencies billing case management services:* The rendering provider number is the case manager's number. *For Area Agencies on Aging billing for other waiver services, not case management:* The rendering provider number is the agency's rendering number issued by EDS. *For all other providers:* The rendering provider number is the regular waiver provider number.
28	Total Charge	Enter the sum of all the amounts in box 24f.

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Table 1.3 - HCFA 1500 Waiver Claims Instructions

Box Number	Description	Instructions
29	Amount Paid	**For all waiver claims for recipients with spenddown, always enter $0 in this box.** EDS will automatically deduct the spenddown amount listed on the *Form 8A*, from the total amount of the claim. **For waiver members without spenddown**, no entry is necessary in this box. A waiver member may meet spenddown with a waiver service, with a regular IHCP services, or IHCP-covered medication. **All waiver services can count toward meeting spenddown.** Until a member has incurred medical or waiver expenses in an amount that meets the spenddown, those services are not reimbursable through the Indiana Waiver Program. However, once the spenddown amount is met, the remainder of waiver services **are** covered under the Indiana Waiver Program. Note: For spenddown, a provider must submit a *Form 8A* for a member if billing for services rendered on the date spenddown was met, even if member met his or her spenddown with another provider. **When billing on a paper claim**, a *Form 8A* **must** be attached to the HCFA 1500 when it is submitted to EDS. **For electronic claims**, if the claim requires a *Form 8A*, it will suspend, and Indiana*AIM* will send a claim correction form (CCF). Attach the *Form 8A* to the CCF and return it to EDS for the claim to finish processing. Obtain the *Form 8A* from the county Division of Family and Children (DFC). If billing only for services provided **after** the date spenddown was met for the month, a *Form 8A* is not necessary.
30	Balance Due	Enter amount listed in box 28.
31	Signature of Physician or Supplier	Enter provider signature. A signature stamp is acceptable, however, a typed signature is **not** acceptable.
33	Physician's or Supplier's Billing Name, Address, ZIP Code, and Phone Number	Enter the name, address, and phone number of provider. Also include the waiver provider number in the **GRP#** portion. No entry should be included in the **PIN#** portion of this box. Note: For case management agencies only, the case manager's number should **not** be entered in box 33. The case manager's individual number should be entered as the rendering provider in box 24k. All other providers, including independent case managers, should use their number in box 24k.

Submit completed HCFA 1500 waiver claims, with any additional required documentation (see Table 1.4 for more information) to the following address:

EDS
Waiver Programs Claims
P.O. Box 68923
Indianapolis, IN 46268-0923

Please submit completed HCFA 1500 waiver claims and additional documentation to the following address after April 1, 2000:

EDS
Waiver Programs Claims
P.O. Box 7269
Indianapolis, IN 46207-7269

Table 1.4 – Claims which require attachments with the HCFA 1500

Type of Claim	Attachment Required
Dates of service include date spenddown was met	*Form 8A* from the DFC office
Home modifications	Request for *Approval to Authorize Services Form*
Adaptive aids and devices	Request for *Approval to Authorize Services Form*
Assistive devices	Request for *Approval to Authorize Services Form*
Environmental modifications	Request for *Approval to Authorize Services Form*

Claims submitted without the necessary attachment will be denied, so it is **important** to ensure the correct attachment is included with the claim.

Additional Information

If there are additional questions on the TBI Waiver Program, contact the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.