Home Health, Hospice, and Long-Term Care
Billing Tips and Reminders

HP Provider Relations/October 2014
Agenda

• Claim inquiry on Web interChange
  – By member number and date of service
  – Understand claim status information, disposition, and explanation of benefits (EOB) description

• Check/RA inquiry
  – Zero pay remittance advices (RAs)

• Covered services, reimbursement, and billing

• Frequently asked questions

• Helpful tools

• Question and answer
Objectives

Participants will understand:

- How to research institutional claims on Web interChange
- Importance of downloading RAs on Web interChange
- Covered services, reimbursement, and billing
- Frequently asked questions
Claim Inquiry
Claim Research on the Web
Claim Research on the Web

• National Provider Identifier (NPI) will automatically populate
  – For multiple locations – choose appropriate service location from drop-down options
• Member identification number (RID)
• From and through date of service (DOS) of specific claim
• Search by DOS
• Why not search by internal control number (ICN)?
  ICN will only give information on one specific claim
  – Review all claim submissions and denial reasons
  – Use paid claim (if applicable) for corrections
    ➢ Adjust the paid claim or void and start over
Claim Research on the Web
Claim Research on the Web

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<table>
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HIPAA-required fields – Do not give specifics on why the line item denied

ARC Code 178 – patient liability/waiver liability
Claim Research on the Web

- Claim submission information is displayed
  - Choose the appropriate claim to work with (for example, most recent ICN or paid claim)
  - Click on the ICN
  - Choose
  - Scroll to the bottom of the claim
- Adjustment reason codes (ARCs)
  - *Health Insurance Portability and Accountability Act (HIPAA)*-required fields – not the reason detail denied
- Remarks
  - HIPAA-required fields – not the reason detail denied
  - Provide patient liability/waiver liability information
Claim Research on the Web

Claim status information

• Provides detailed information
  – Disposition of each EOB code – Look for the “D”
  – H/D – The header or detail level
    ➢ Which detail line

• Why did the claim/detail line deny?
  – Description
Check/RA Inquiry
Check/RA inquiry on the Web

Check/RA Inquiry

Search Criteria

Search For: NPI Legacy Provider ID

NPI: ________________________

MCO ID: _____________________ Region: ______

Check Number: __________ From Date: 06/01/2014 To Date: 08/06/2014

Check/RA Inquiry

Claim Inquiry

Claim Submission

CS Notif Inquiry

Eligibility Inquiry

MRO Inquiry

NOP Inquiry

PA Inquiry

Pharm Member Profile

Providers ProFile

Date	Provider ID	Service Loc	Check #	Type	Status	Amount	Download RA
08/06/2014					EFT	Issued		
07/23/2014					EFT	Issued		
07/15/2014			000000000	EFT	Issued		
07/09/2014					EFT	Clear		
Check/RA Inquiry on the Web

Reasons for zero pay remits

Provider Initiated

Internal Control Number (ICN)

Adjustments

50 – Noncheck related
51 – Check related
61 – Electronic with attachment
62 – Electronic, no attachment or claim notes

Voids

63 – Any paid amounts on the claim are RECOUPED
Check/RA Inquiry on the Web

Reasons for zero pay remits

**HP Generated Mass**

Internal Control Number (ICN)

**Adjustments**

- 55 – Institutional rate adjustments
- 56 – System generated
- 60 – Nonclaim-specific financial transactions
  
  (LTC monthly bed tax assessment fee)

**Voids**

- 54 – Void
  
  Any paid amounts on the claim are RECOUPED
Check/RA inquiry on the Web
Electronic Remittance Advice – RA

• Providers receiving electronic Remittance Advices (RAs) from software vendors or via 835 transaction should verify:
  – Zero pay RAs are sent to provider
  – Adjustments and voids are posting correctly to accounts
  – Accounts receivable details are on RA
  – Nonclaim-specific adjustments/payouts are on the RA

• Duplicate copies of RAs may be requested by contacting Customer Assistance to verify the cost and then submitting a request with the payment to:
  – **HP Provider Written Correspondence**
    P.O. Box 7263 Indianapolis, IN 46207-7263

*Note: It is the provider’s responsibility to verify checks are received and cashed in a timely manner and electronic funds transfers (EFTs) are deposited in the correct account*
Billing Tips and Reminders
Home Health

IHCP Provider Manual, Chapter 8, Section 2

• Home health services
  – Available to members medically confined to the home when services are ordered in writing by a physician and performed in accordance with a written plan of care
  – Require prior authorization

Exception: Up to 120 units of registered nurse (RN), licensed practical nurse (LPN), or home health aid services, or 30 units of therapy, within 30 days of hospital discharge when ordered in writing by physician prior to discharge
  ➢ Use occurrence code 50 and hospital discharge date in fields 31-34, a-b
Home Health

- Revenue and Healthcare Common Procedure Coding System (HCPCS) codes
  - 42X - G0151 – Physical therapy in home health setting
  - 43X - G0152 – Occupational therapy in home health setting
  - 44X - G0153 – Speech therapy in home health setting
  - 552 - 99600 – Skilled nursing home health visit (modifier TD for RN and TE for LPN or licensed vocational nurse (LVN))
  - 572 - 99600 – Home health aide home health visit

Reminder – When requesting prior authorization (PA) for nursing services:

- PAs must reflect the appropriate home visit nursing code
  - PAs for nursing services do not need to indicate whether an RN or 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
    - 99600 TD – Unlisted home visit, service, or procedure – RN
    - IndianaAIM uses the approved PA units for the RN service 99600 TD

IHCP Provider Manual, Chapter 6, Section 2
Home Health

Units of service

• Home health aide, LPN, and RN visits are based on one-hour units
  – Round to the nearest unit
    ➢ If in the home for less than 29 minutes, providers can bill for the entire first hour if a service was provided

• Therapy visits are based on 15-minute units of service
  – Round to the nearest unit
    ➢ If therapist is in the home less than eight minutes, the service cannot be billed

• Bill each date of service as a separate line item

• Bill each level of service, such as RN or LPN, as a separate line item, for each date of service
  – If the same service is provided, such as multiple RN visits on the same day, the services should be combined and billed on one claim

Note: See IHCP Provider Bulletin BT201428 for the 2015 fiscal year rates
Home Health

Overhead rate

• For each encounter at home, home health providers receive an overhead rate for administrative costs.

• If the dates of service billed are not consecutive, enter occurrence code 61, and the date, for each date of service.

• If the dates of service are consecutive, enter occurrence code 61 and the occurrence span dates.

TIP – The number of entries for occurrence codes are limited on claim submission – Plan ahead.

• Providers can only report one overhead encounter per recipient per day.
  – In a multi-member situation (for example, husband and wife both treated during same encounter), only one overhead is allowed.
Home Health
Overhead rate – UB-04 paper claim

Occurrence code 61 and individual dates

Occurrence code 61 and date span
Home Health

Overhead rate – Institutional claim on the web
Hospice

• To be eligible for program services, Indiana Health Coverage Programs (IHCP) members must:
  – Have a prognosis of six months or less to live
  – Must elect hospice services
    ➢ Hospice providers should ensure that Hoosier Healthwise and Care Select members disenroll from the respective program before the member elects the hospice benefit

• Available hospice services include, but are not limited to:
  – Palliative care for physical, psychological, social, and spiritual needs of the patient

• Hospice providers can provide hospice care to an IHCP member
  – In an inpatient setting
  – In the member’s home
Hospice
Election by member

• Member must elect hospice services by:
  – Completing a *Medicaid Hospice Election State Form 48737 (R2/1-12)*
    ➢ Form can be downloaded from the *Forms* page at indianamedicaid.com
  – Indicating a particular hospice provider

• According to *42 USC 1395d(d)(2)* and *405 IAC 5-34-6(b)*, election to the hospice benefit requires the member to **waive** the following:
  – Other forms of healthcare for treatment of the terminal illness for which hospice care was elected or for treatment of a condition related to the terminal illness
  – Services provided by another provider equivalent to the care provided by the elected hospice provider
  – Hospice services other than those provided by the elected hospice provider or its contractors
Hospice

Exception: Election by members age 20 or younger

• Children are not required to waive other forms of healthcare for treatment of the terminal illness *(See BT201205)*

• Concurrent hospice care and curative care benefits available
  – Palliative treatment and management of terminal condition supervised by Hospice provider
  – Curative care services covered separately by the IHCP

• Hospice plan of care and a curative plan of care must both be submitted for hospice PA review
  – PA for curative care only required if IHCP covered service requires PA
  – *Medicaid Hospice Plan of Care for Curative Care – Members 20 Years and Younger* – available on the Forms page at indianamedicaid.com

• No changes to Hospice billing
  – Curative care services reimbursed separately
Hospice

- Hospice providers must submit the hospice election form to ADVANTAGE
  - ADVANTAGE staff can coordinate with the managed care enrollment broker to disenroll the member from managed care
  - The hospice-dedicated fax number for managed care disenrollment is (317) 810-4488
  - Hospice authorization starts the date after the member is disenrolled from managed care
    - It is recommended hospice providers follow up the fax with a telephone call to ADVANTAGE, notifying ADVANTAGE staff that a fax has been sent for disenrollment of a hospice member from managed care

Note: See Hospice Provider Manual, Section 5
Hospice

Revenue Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>651</td>
<td>Routine home care in private home</td>
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<tr>
<td>652</td>
<td>Continuous home care in private home</td>
</tr>
<tr>
<td>653</td>
<td>Routine home care in nursing facility</td>
</tr>
<tr>
<td>654</td>
<td>Continuous home care in nursing facility</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient respite care</td>
</tr>
<tr>
<td>656</td>
<td>General inpatient hospice</td>
</tr>
<tr>
<td>657</td>
<td>Hospice direct care physician service</td>
</tr>
<tr>
<td>659</td>
<td>Medicare/IHCP dually eligible nursing facility members</td>
</tr>
</tbody>
</table>

Type of Bill

- **822** – Special facility-hospice

Note: Each date of service must be entered on a separate line when submitting claims
Long-Term Care

IHCP Provider Manual, Chapter 14

Inpatient long-term care (LTC) services are available to members who meet the threshold of nursing care needs required for admission to, or continued stay in, an IHCP-certified facility

- FSSA Form 450B, Physician Certification for Long Term Care Services, is required for placement in an LTC facility
  - Form 450B can be accessed online with the state of Indiana at in.gov/icpr
  - To access the e-450B along with reference materials for completing, uploading, and downloading the required documents, see myweb.in.gov/FSSA/aging/form450b
- An approved 450B, with a Medicaid effective date, is required for IHCP reimbursement
Long-Term Care
Revenue codes

- Room and board
  - 110 – Room and board private
  - 120 – Room and board semiprivate (two beds)
  - 130 – Room and board semiprivate (three or four beds)

- Bed-hold days may be reported on the claim
  - 180 – Bed-hold days
  - 183 – Therapeutic bed-hold days
  - 185 – Hospital bed-hold days

Bed hold days for LTC are not reimbursed
Long-Term Care

Discharge status codes

To ensure that all IHCP members receive all the benefits to which they are entitled, it is the responsibility of each LTC provider to properly document the discharge of residents in a timely manner.

- The patient status code on the claim form is used to close the member’s Level of Care (LOC)
  - This eliminates the need to submit written discharge information to the Family and Social Services Administration (FSSA)
  - Use of incorrect status codes can result in overpayments and prevents members from receiving services, such as supplies and pharmacy prescriptions, after discharge from the LTC facility.

See IHCP Provider Manual, Chapter 14, Section 8
Long-Term Care

Retro-rate adjustments

• LTC reimbursement is based on Case Mix methodology
• Myers and Stauffer (the rate-setting contractor) calculates the provider approved rates
  – Once the rates are established, the facility is notified by letter of the new rate and the effective date of the new rate
    ➢ Audit reviews are conducted quarterly to review provider rates
    ➢ Myers and Stauffer electronically transmits to HP the rate changes on a nightly basis
• Paid claims are mass adjusted to correct the provider rate
  – Retro-rate mass adjustment ICNs begin with a 55
  – HP deactivates the autoclosure process for retro-rate adjustments

See IHCP Provider Manual, Chapter 14, Section 8
Hospice and Long-Term Care

• LTC Responsibility
  – Obtain an **approved 450B**, with a Medicaid **effective date**
    ➢ Required for IHCP **reimbursement**
    ➢ **LTC does not bill for room and board**

• Hospice Responsibility
  – Submit claims with the appropriate revenue code indicating member is in an LTC facility
  – Submit claims with the appropriate discharge status code for hospice services

• Retro-rate Adjustments
  – Hospice claims billed under bill type 822 and for hospice revenue codes 653, 654, 659, 183, and 185 are automatically mass adjusted
  – Retro-rate mass adjustment ICNs begin with a 55
Frequently Asked Questions
FAQ

Member was discharged from the LTC to Home Health – the first day of the claim (same day as discharge) is denied, but the rest paid?

• Special processing is required for:
  – Home and community-based services overlapping hospice Level of Care (LOC) or long-term care discharge dates
  – Claims submitted for waiver services on the client’s date of discharge from the LTC facility or during a period of hospice LOC
  ➢ Contact HP field consultant for special claim handling
  ➢ To locate the HP field consultant assigned to your area, click the Contact Us link at the top right side of the indianamedicaid.com Provider Home Page
FAQ

Why did LTC mass-adjusted claim for retro rate deny?
• Verify member’s LOC eligibility on the web
• Verify discharge status code on claims previously submitted

Patient liability appears to be deducted twice during the retro-rate adjustment – why?
• Liability may be deducted or paid on a different claim for the same month during retro-rate adjustment
• Verify retro-rate adjustments for the entire month on claim inquiry on the web
FAQ

Can a member have home health and hospice at the same time?

• In specific circumstances when:
  – Diagnosis and ICD-9 code for the terminal and the nonterminal illness are not related
  – Thorough explanation of the medical necessity that clearly documents that there is no relationship between the terminal illness and the required or requested home health treatments outlined in the PA request

**Important Note:** The hospice provider must submit the hospice plan of care and the home health plan of care to the Medicaid PA contractor to ensure a comprehensive review

See Hospice Provider Manual, Section 6, for additional information
FAQ

Home health claim for waiver member denies for dates of service not on PA Master File

• Verify claim was billed with the same procedure code, including all modifiers as indicated on the Notice of Action (NOA) or Prior Authorization (PA)
• Verify dates of service are on the NOA or PA
• Verify dates of service billed on claim do not overlap multiple NOAs or PAs
FAQ

I replaced a claim on the web – why was all the money taken back?
• Claims with a date of service more than one year old from the current date will systematically deny for timely filing when replaced on the web
• In this instance, a paper adjustment with proof of timely filing is required

Member is within the hospital discharge time frame for home health without a prior authorization – why did the claim deny?
• Providers should use occurrence code 50 with the corresponding date of discharge in the occurrence code and occurrence date fields 31-34, a–b on the UB-04, on every claim within this time frame
Helpful Tools
Helpful Tools

Avenues of resolution

- IHCP website at indianamedicaid.com
- IHCP Provider Manual
- Customer Assistance
  - 1-800-577-1278
- Locate area consultant map on:
  - indianamedicaid.com (provider home page > Contact Us > Provider Relations Field Consultants)
  - Web interChange > Help > Contact Us
- Written Correspondence
  - HP Provider Written Correspondence
    P. O. Box 7263
    Indianapolis, IN 46207-7263
Q&A