

Home and Community- Based Services Waiver Program

HP Provider Relations/October 2014

Agenda

- Objectives
- Overview of the Home and Community-Based Services (HCBS) Waiver Program
- Member eligibility
- Billing information
- Electronic claim filing
- Paper claim filing hints
- Remittance Advice (RA)
- Claim voids and replacements
- Common denials
- Helpful tools



Objectives

At the end of this session, providers will understand the following:

- Origin of the Medicaid waiver program
- Member eligibility process for Waiver services
- Requirements necessary for a member to qualify for waiver services
- How to verify member eligibility
- How to submit and adjust claims

Medicaid Waivers

What Is the Home and Community-Based Services Waiver Program?

- In 1981, the federal government created the Title XIX HCBS Program
- This program, referred to as the waiver program, created exceptions to or “waived” traditional Medicaid requirements
- The state government requested a waiver from the Centers for Medicare & Medicaid Services (CMS) to obtain additional funding through the Medicaid program
- The waiver allows for the provision and payment of HCBS that are not provided through the Medicaid state plan
- Medicaid waiver programs are funded with state and federal dollars



What Is the Home and Community-Based Services Waiver Program?

- The Medicaid HCBS waivers fund supportive services to individuals in their own homes or in community settings rather than in a long-term care facility setting
- The Medicaid HCBS waivers fund services to the following:
 - Individuals who meet the level of care specific to a waiver
 - Individuals who meet the financial limitations established by the waiver

What Is the Home and Community-Based Services Waiver Program?

- In addition to waiver services, waiver members receive all Medicaid services under the State plan (Traditional Medicaid) for which they are eligible
- The State administers five HCBS waivers and one grant under three distinct governmental divisions



Home and Community-Based Services Waivers

- Administered by the Division of Aging (DA)
 - Aged and Disabled (AD) Waiver
 - Traumatic Brain Injury (TBI) Waiver
 - Money Follows the Person (MFP) Demonstration Grant
- Administered by the Division of Disability and Rehabilitative Services (DDRS)
 - Community Integration and Habilitation (CIH) Waiver (formerly Developmental Disabilities and Autism waiver)
 - Family Supports (FS) Waiver (formerly Support Services waiver)
- Administered by Division of Mental Health and Addiction (DMHA)
 - Psychiatric Residential Treatment Facility (PRTF) Transition Waiver (formerly CA-PRTF Grant)

Home and Community-Based Services Waivers

- The Community Alternative to Psychiatric Residential Treatment Facilities (CA-PRTF) Demonstration Grant ended September 30, 2012
- Transitioned to PRTF Transition Waiver effective October 1, 2012



PRTF Transition Waiver

- *Deficit Reduction Act* (DRA) of 2005 authorized the transition from CA-PRTF Grant to the PRTF Transition Waiver October 1, 2012
- Under the DRA, only participants on the grant (as of September 30, 2012) were allowed to transition to the waiver October 1, 2012
- The DRA does not allow for any additional participants to be added to the waiver after October 1, 2012
- Waiver eligibility, services, provider qualifications, and policies and procedures remain unchanged following the transition from grant to the waiver



Money Follows the Person

Overview

- Demonstration grant through the CMS
- Helps interested individuals transition from a nursing facility or PRTF to a community-based setting
- Case managers from ADVANTAGE Health SolutionsSM help facilitate transition
- Participants may receive waiver services plus the following additional program services:
 - Additional transportation
 - Personal Emergency Response System
- After 365 days, participants transfer seamlessly to one of the waivers

Indiana Family and Social Services Administration Waiver Divisions

- The following divisions support the administration of the HCBS waivers and grants:
 - CIH and FS Waivers
Division of Disability and Rehabilitative Services
402 W. Washington St., Room W451
Indianapolis, IN 46207
Telephone: 1-800-545-7763
 - AD and TBI Waivers and MFP Demonstration Grant
Division of Aging
402 W. Washington St., Room W454
Indianapolis, IN 46204
Telephone: 1-888-673-0002
 - PRTF Transition Waiver
Division of Mental Health and Addiction
402 W. Washington St., Room W353
Indianapolis, IN 46204
Telephone: 1-800-901-1133

Member Eligibility

Member Eligibility

Division of Family Resources

- The Medicaid enrollment process starts with the Division of Family Resources (DFR), which performs the following:
 - Enters a member's application into the eligibility tracking system known as the Indiana Client Eligibility System (ICES)
 - Determines a member's eligibility status
 - Maintains member information and eligibility files



Member Eligibility

Exception to the rule

- If an individual meets waiver level of care (LOC) requirements but is not eligible for Medicaid, the individual may become eligible for Medicaid under special waiver eligibility rules

Member Eligibility

- Members must qualify for waiver program eligibility
- Individuals who meet waiver LOC status and are eligible for Medicaid may be approved to receive waiver services
- A limited number of slots are available for each waiver
- An individual who is eligible for Medicaid cannot receive waiver services until the following occur:
 - A funded slot is available
 - A waiver LOC is established for the member
 - A service plan is approved (the budget demonstrates the cost-effectiveness of waiver services when compared to institutional costs)

Member Eligibility

Once eligibility requirements are met, the following occur:

- An individualized service plan is developed by a case manager, the client and/or the client's representative, and other service providers and is reviewed by the State
- Information from the service plan is incorporated into a Notice of Action (NOA)
 - The NOA lists the approved services that the client may receive along with the approved date span, units, and charge per unit
- Information from the NOA is sent to Hewlett-Packard (HP) for placement on the member's prior authorization (PA) record
- Services are provided and claims are paid
 - A claim pays only if PA dollars, units, and services are available for the dates of service submitted on the claim
 - An approved NOA is not a guarantee of payment for a claim; providers must verify member eligibility to ensure Medicaid coverage and waiver LOC

Member Eligibility

HP role

- Receives member data from ICES
- Updates IndianaAIM within 72 hours
- Provides and supports the Eligibility Verification System (EVS)
- Makes EVS available 24 hours a day, seven days a week

Member Eligibility

Eligibility Verification System

- It is the provider's responsibility to verify a member's eligibility prior to providing a services
- The following two EVS options are available:
 - Web interChange
 - Automated Voice Response (AVR)



Member Eligibility

Eligibility Verification System using Web interChange

- The following is available through Web interChange:
 - Recipient information such as identification number (RID), Social Security number, Medicare number, or name and date of birth
- [Web interChange](http://indianamedicaid.com) is accessible at indianamedicaid.com





Eligibility Inquiry

interChange Home

Indiana Medicaid

Birth Expenditures

Check/RA Inquiry

Claim Inquiry

Claim Submission

CS Notif Inquiry

■ Eligibility Inquiry

MRO Inquiry

NOP Inquiry

PA Inquiry

Pharm Member Profile

Provider Profile

User Lists

User Profile

Help

FAQ

How to Obtain an ID

Contact Us

Logon

Logout

Query Information

Search For: NPI Legacy Provider ID

Legacy Provider ID Service Location

Search Criteria

Member ID

From Date To Date

Eligibility Information

Member is Eligible from 03/19/2012 to 03/19/2012 for PACKAGE A STANDARD PLAN

Inquiry completed at 2:24:33 PM on 3/19/2012

Member Name Member ID

Address

Date of Birth

Spend Down No

Medicare No

Nursing Home Resident **WAVER**

Restricted No

QMB No

Other Private Insurance No

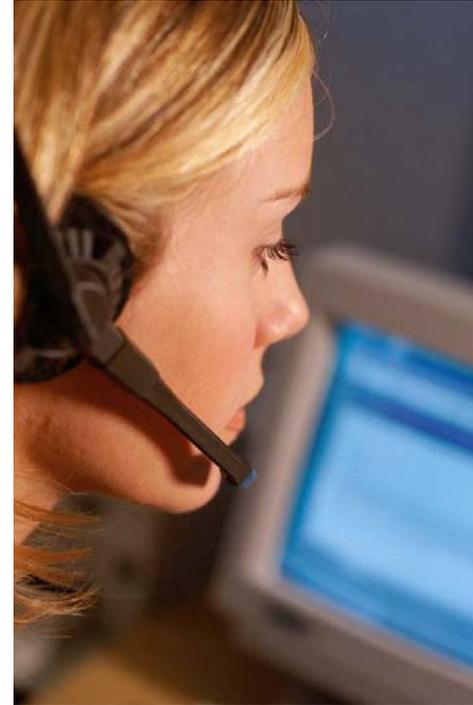
Medicare Number

Patient Liability \$0.00

Member Eligibility

Eligibility Verification System using the telephone

- AVR provides the following:
 - Member eligibility verification
 - Benefit limits
 - PA verification
 - Claim status
 - Check/RA inquiry
- Contact AVR at toll-free at 1-800-738-6770



Waiver Billing Information

Waiver Billing

- When billing for HCBS waiver services, it is important to have the NOA available to bill properly
- The NOA lists the following information:
 - Approved service providers
 - Approved service codes and modifiers
 - Approved number of units and dollar amounts
 - Units on the NOA may be in time increments



Waiver Billing

Authorized Services

- Only authorized services may be billed
- For services to be authorized, they must fulfill the following criteria:
 - Meet the needs of the member
 - Be addressed in the member's service plan and be identified on the NOA
 - Be provided as the services that are defined and established by the waiver program



Waiver Billing

- Waiver providers should submit their claims electronically via the 837P transaction or Web interChange
- The *CMS-1500* claim form is used when submitting paper claims
- Waiver providers are considered atypical and do not report a National Provider Identifier (NPI) on their claims
- Waiver providers do not report or use a taxonomy code
- Waiver providers submit claims using their waiver Legacy Provider Identifier (LPI) with the alpha location suffix

Primary Diagnosis Required

BR201210

- Effective April 1, 2012
- Required for paper and web interChange claim submissions
- Waiver providers should bill ICD-9 diagnosis code 7999 as primary diagnosis code when the actual diagnosis is not known
- Web interChange claims submitted without a ICD-9 primary diagnosis code or 7999 generates the following error message: “primary diagnosis is required”
- Paper claims missing the primary diagnosis code will be denied for edit 258 – *Primary diagnosis code missing*



Electronic Claim Filing

Billing Information

Quick Reference Guide

Welcome to Web interChange

interChange Home
Indiana Medicaid
Help
FAQ
How to Obtain an ID
Contact Us
Logon
Logoff
Reset Password

Help

Web interChange Basics

- [Frequently Asked Questions](#)
- [User IDs and Passwords](#)
- [Printing Tips](#)
- [System Requirements](#)
- [Automated Password Reset](#)

Reference Materials

- [Attachment Cover Sheet](#)
- [Sending Claim Attachments](#)
- [IHCP Companion Guides](#)
- [HCP Provider Manual](#)
- [Quick Reference for Billing Institutional Claims](#)
- [Quick Reference for Billing Medical Claims](#)**
- [Quick Reference for Billing Dental Claims](#)
- [Quick Reference for Submitting Prior Authorizations](#)
- [X12N Approved Implementation Guides](#)
- [Medicaid Payer IDs](#)
- [Clear Claim Connection User Manual](#)

Transaction Help

- [Care Select Notification Help](#)
- [Check/RA Inquiry Help](#)
- [Claim Submission Help](#)
- [Claim Inquiry Help](#)
- [Eligibility Verification Help](#)
- [File Exchange Help](#)

Contact Us

- [Customer Assistance](#)
- [Field Consultants](#)
- [Web Help Desk](#)

Web interChange

Quick Reference Guide

Claims Processing Menu

- interChange Home
- Indiana Medicaid
- Birth Expenditures
- Check Inquiry
- Claim Inquiry
- Claim Submission
- Eligibility Inquiry
- NOP Inquiry
- PA Inquiry
- Provider Profile
- User Lists
- User Profile
- Help
- FAQ
- How to Obtain an ID
- Contact Us
- Logon
- Logoff
- Change Password

Institutional Claims

- [Inpatient](#)
- [Outpatient](#)
- [Home Health](#)
- [Long Term Care](#)
- [Institutional Crossover](#)
- [Outpatient Crossover](#)

Professional Claims

- [Medical](#) (includes HCBS Waiver)
- [Medical Crossover](#)

Dental Claims

- [Dental](#)

Helpful Hints

- ◆ Use the [NPI Reporting Tool](#) to report your National Provider Identifier (NPI) to IHCP.
- ◆ Click on any field label to get more information about the field.
- ◆ Review the [Help Page](#) to find more information about how to use this site.
- ◆ Please direct comments, problems or suggestions concerning using this site to [Indiana Medicaid](#).



Claim Completion

Professional Claim

* denotes a required field.

Billing Information

* NPI	<input type="text"/>	Postal Code	<input type="text"/> - <input type="text"/>	Taxonomy	<input type="text"/>
* Legacy Provider Id	<input type="text"/> <input type="button" value="A"/>				
* Member ID	<input type="text"/>				
* Last Name	<input type="text"/>	* First Name	<input type="text"/>	* Patient Account #	<input type="text"/>
Rendering Provider	<input type="text"/>	Rendering NPI	<input type="text"/>	Rendering Taxonomy	<input type="text"/>
Referring Provider	<input type="text"/>	Referring NPI	<input type="text"/>	Referring Taxonomy	<input type="text"/>
Certification Code	<input type="text"/>	* Signature Indicator	<input checked="" type="radio"/> Yes <input type="radio"/> No	Medical Record #	<input type="text"/>

[Notes...](#)

[Attachments...](#)

Service Information

Claim Type	Medical	* Place of Service	<input type="text" value="12"/>
Hospital From Date	<input type="text"/>	Hospital To Date	<input type="text"/>
Pregnancy?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Last Menstrual Period	<input type="text"/>
Accident Related to	<input type="checkbox"/> Auto <input type="checkbox"/> Employment <input type="checkbox"/> Other Accident	Special Program	<input type="checkbox"/>

Coordination of Benefits

Total TPL	<input type="text"/>
Total Medicare Paid	<input type="text"/>

[Benefit Information](#)

Claim Completion

Billing Codes

Diagnosis Code

Primary
Diag 3
Diag 5

Charges

Total Charges

Detail Information

Detail # * From DOS * To DOS
Place of Service Procedure Code Modifiers
Related Diagnosis * Units * Charges
* Emergency? Yes No Line Item Control # * EPSDT Referral Yes No
Rendering Provider
NDC Quantity Unit of Measure

Notes...

Detail Benefits Info

Other Payer Info

Save Detail

Reset Detail

Detail #	From DOS	To DOS	Procedure	Modifiers	Units	Charges
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1	07/12/2010	07/12/2010	S5101	U7 U2	4.00	16.00
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Add Detail

Delete Detail

Copy Detail

Paper Claim Filing

CMS-1500 Claim Form

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by)										Field 21 ICD Ind.: Enter 9 to indicate ICD-9 Required										ER																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (State A-L to service line below (24E))										ICD Ind.										22. SUBMISSION CODE ORIGINAL REF. NO.																																							
A. _____ B. _____ C. _____ D. _____										←										Fields 21A-L: Enter the diagnosis codes in priority order. A total of 12 codes can be entered. Required																																							
E. _____ F. _____ G. _____ H. _____										←																																																	
I. _____ J. _____ K. _____ L. _____										←																																																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE FMS										C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										D. DIAGNOSIS POINTER																													
1										Field 24E: Enter letter A-L corresponding to the applicable diagnosis codes in fields 21A-L. A minimum of one and a maximum of four, diagnosis code references can be entered on each line. Required										NPI																																							
2																				NPI																																							
3																				NPI																																							
4																				NPI																																							
5																				NPI																																							
6																				NPI																																							
25. FEDERAL TAX ID. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For gov. contracts, see 24D) YES NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. Round for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & Field 30: Balance Due is no longer required.																																							
SIGNED										DATE										a.										b.										c.										d.									

PHYSICIAN OR SUPPLIER INFORMATION

Paper Claim Filing

CMS-1500 instructions

- 1: INSURANCE CARRIER SELECTION – Enter **X** for Traditional Medicaid
- 1a: INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) – Enter the IHCP member identification number (RID). Must be 12 digits
- 2: PATIENT'S NAME (Last Name, First Name, Middle Initial) – Provide the member's last name, first name, and middle initial obtained from the Automated Voice Response (AVR) system, electronic claim submission (ECS) or Web interChange verification
- 21.1: DIAGNOSIS – **7999** will always be used when billing waiver services if the member diagnosis is unknown by the service provider
- 24A: From and To dates of service
- 24B: Place of service
- 24D: Billing service code in conjunction with appropriate modifiers

Paper Claim Filing

CMS-1500 instructions

- **24E: DIAGNOSIS CODE** – Enter Letter A-L corresponding to the applicable diagnosis codes in field 21. A minimum of one, and a maximum of four, diagnosis code references can be entered on each line.
- **24F: \$ CHARGES** – Enter the total amount charged for the procedure performed, based on the number of units indicated in field 24G.
- **24G: DAYS OR UNITS** – Provide the number of units being claimed for the procedure code. Six digits are allowed.
- **24I: ID QUAL (top half – shaded area)** – Enter a 1D qualifier for the rendering provider ID.
- **24J: RENDERING PROVIDER ID # (top half – shaded area)** – If entering an LPI, the entire nine-digit LPI must be used. If billing for case management, the case manager's number must be entered here.



Paper Claim Filing

CMS-1500 instructions

- 28: TOTAL CHARGE – Enter the total of all service line charges in column 24F
- 29: AMOUNT PAID – Enter .00 in this field
- 31: SIGNATURE – Enter the date the claim was filed
- 33: BILLING PROVIDER INFO & PH # – Enter the billing provider office location name, address, and the ZIP Code+4
- 33b: Enter the qualifier **1D** and the LPI



Paper Claim Filing

Helpful hints

- Verify that the claim form is signed or complete the Claim Certification Statement for Signature on File
- Send paper claims to the following address:
 - HP Waiver Program Claims
P.O. Box 7269
Indianapolis, IN 46207-7269
- Review the RA closely and adjust any claims that did not process as expected



Remittance Advice

Statement with claims processing information

- RAs provide information about claims processing and financial activity related to reimbursement including the following:
 - Internal control numbers with detail-level information
 - Claim status (paid or denied)
 - Total dollar amount claims paid, denied, and adjusted
- RAs are available on Web interChange
 - Under the Check/RA Inquiry tab
 - For more information, see [Chapter 12](#) of the *IHCP Provider Manual* at indianamedicaid.com



Claim Adjustments

Replacements and voids

- Replacements and voids are performed using Web interChange
- “Replacement” is a Health Insurance Portability and Accountability Act (HIPAA) term used to describe the correction of a submitted claim
- “Replacements” can be performed on claims in a paid, suspended, or denied status
- Denied details can be replaced or rebilled as a new claim
- To avoid unintentional recoupments, submit paper adjustments for claims finalized more than one year from the date of service
 - Paper adjustments can only be processed on claims in a paid status
- “Void” is the term used to describe the deletion of an entire claim
- Voids can be performed on paid claims only

Most Common Denials

Most Common Denials

Edit 5001 – *Exact duplicate*

- Cause:
 - The claim is an exact duplicate of a previously paid claim
- Resolution:
 - No action is required as the claim has already been paid



Most Common Denials

Edit 4216 – *Procedure code not eligible for recipient waiver program*

- Cause:
 - Provider has billed a procedure code that is invalid for the waiver program
- Resolution:
 - Verify the correct procedure code has been billed
 - Verify the procedure code billed is present on the NOA
 - Correct the procedure code and rebill your claim

Most Common Denials

Edit 2013 – *Recipient ineligible for level of care*

- Cause:
 - Waiver provider has billed for a member who does not have a waiver LOC for the date of service
- Resolution:
 - Contact the waiver case manager to verify the LOC information is accurate
 - Verify that the correct date of service has been billed
 - If the code billed is incorrect, correct the code and rebill

Most Common Denials

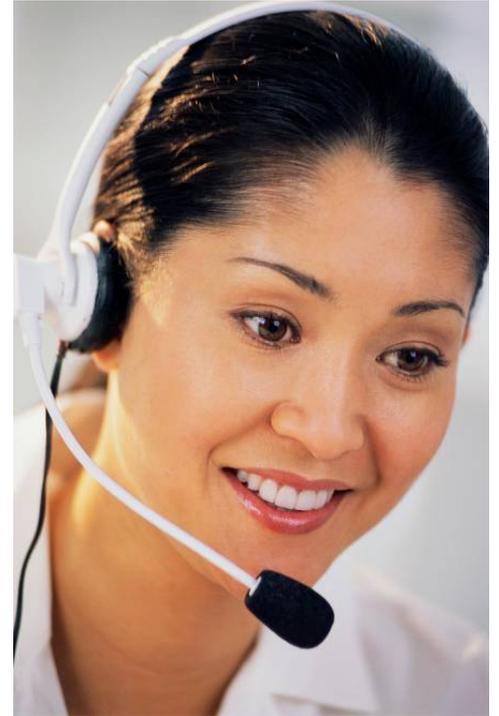
Edit 3001 – *Date of service not on PA database*

- Cause:
 - The date of service billed is not on the PA file
- Resolution:
 - Verify the correct date of service has been billed
 - Verify that the date of service billed is on the NOA
 - Verify the procedure code billed is present on the NOA
 - Contact the INsite Helpdesk to verify the NOA is correct (317) 232-7858

Find Help

Helpful Tools

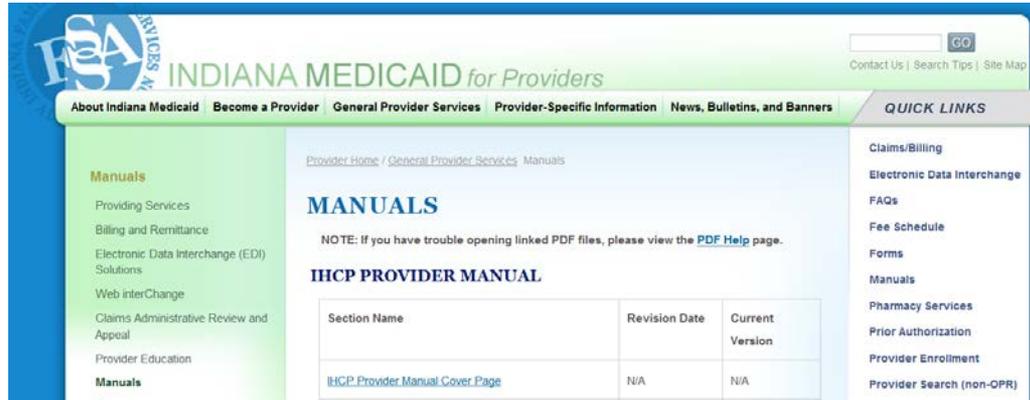
- IHCP website at indianamedicaid.com
- [IHCP Provider Manual](#) at indianamediciad.com
- INsite Helpdesk via email at insite.helpdesk@fssa.in.gov
 - (317) 232-7858
- Customer Assistance
 - 1-800-577-1278
- Written Correspondence
 - Written Correspondence
 - P. O. Box 7263
 - Indianapolis, IN 46207-7263
- [Provider Relations Field Consultants](#) at indianamedicaid.com



Helpful Tools

Avenues of Resolution

- The following manuals are available from the [Manuals](#) page at indianamedicaid.com:
 - [Division of Aging Home and Community-Based Services Waiver Provider Manual](#)
 - [Division of Disability and Rehabilitative Services Home and Community-Based Services Waiver Provider Manual](#)
 - [Division of Mental Health and Addiction Psychiatric Residential Treatment Facility Transition Waiver Provider Manual](#) (Formerly the *Division of Mental Health and Addiction Home and Community-Based Services Waiver Provider Manual*)



The screenshot shows the Indiana Medicaid for Providers website. The header includes the FSA logo and the text "INDIANA MEDICAID for Providers". A navigation bar contains links for "About Indiana Medicaid", "Become a Provider", "General Provider Services", "Provider-Specific Information", "News, Bulletins, and Banners", and "QUICK LINKS". The "QUICK LINKS" menu includes: Claims/Billing, Electronic Data Interchange, FAQs, Fee Schedule, Forms, Manuals, Pharmacy Services, Prior Authorization, Provider Enrollment, and Provider Search (non-OPR). The main content area is titled "MANUALS" and includes a note: "NOTE: If you have trouble opening linked PDF files, please view the PDF Help page." Below this is a table for the "IHCP PROVIDER MANUAL".

Section Name	Revision Date	Current Version
IHCP Provider Manual Cover Page	N/A	N/A

Helpful Tools

Avenues of Resolution

- Division of Disability and Rehabilitative Services
402 W. Washington St., Room W453
Indianapolis, IN 46204
Telephone: 1-800-545-7763
- Division of Aging
402 W. Washington St., Room W454
Indianapolis, IN 46204
Telephone: 1-888-673-0002
- Division of Mental Health and Addiction
402 W. Washington St., Room W353
Indianapolis, IN 46204
Telephone: 1-800-901-1133



Q&A