IHCP Annual Workshop
October 2017

MDwise Home Health
and Hospice

Exclusively serving Indiana families since 1994.
Agenda

• Who is MDwise?
• IHCP Overview & MDwise Delivery System Model
• What is Home Health Care?
  – Coverage Guidelines
  – Service Limitations
  – Prior Authorizations
  – Billing Procedures
  – Non Covered Services
• What is Hospice Care?
  – Hospice Billing
  – Hospice Prior Authorization
• Tools and Resources
• Questions
Who is MDwise?

MDwise is:

• A local, not-for-profit company serving Hoosier Healthwise and Healthy Indiana Plan members

• Exclusively serving Indiana families since 1994
  • Over 400,000 members
  • 2,000 primary medical providers
IHCP Overview

INDIANA HEALTH COVERAGE PROGRAMS

Traditional Medicaid
Medicaid eligible members are placed in one of the Managed Care Organizations (MCOs) or Health Maintenance Organizations (HMOs) for their primary care needs.

Healthy Indiana Plan (HIP)
HIP is a Medicaid expansion program that provides health care coverage to low-income adults and children.

What is a Delivery System Model?
MDwise serves its Hoosier Healthwise and HIP members under a “delivery system model.” The basis of this model is the localization of health care around a group of providers. These organizations called “delivery systems” are comprised of hospital, primary care, specialty care, and ancillary providers. To serve Medicaid clients in the Hoosier Healthwise and HIP programs, behavioral health providers must be connected to MDwise delivery system providers.
What is a delivery system model?

- MDwise serves its HHW and HIP members under a “delivery system model”
- The basis of this model is the localization of health care around a group of providers
  - These organizations, called “delivery systems” are comprised of hospital, primary care, specialty care, and ancillary providers
What is Home Health Care?

• Home Health Care:
  – Is a wide range of health care services that can be given in your home for an illness or injury
  – Services are ordered in writing from a physician and performed in accordance with the written plan of care
  – Can be provided if medically necessary to assist in day-to-day functions
  – Is for members who are unable to leave home without the assistance of another person or an assistive device, such as a wheelchair or walker
• Coverage is provided through skilled nursing facilities by:
  – Registered nurses or licensed practical nurses
  – Home health care aides
  – Physical, occupational, and respiratory therapists
  – Speech pathologists
  – Renal dialysis providers for home-bound individuals
Home Health Care Services Limitations

Healthy Indiana Plan Members

- HIP Plus:
  - Home health services including therapy - 100 visits per year
- HIP Basic:
  - Home health services including therapy - 100 visits per year
- HIP State Plans:
  - Home health services including therapy - No limits
• Most Home Health Services require prior authorization

  – Exceptions:

  • Services that are ordered in writing by a physician before the member’s discharge from a hospital
  • Services that do not exceed 120 hours within 30 days of discharge
  • Services Such as occupational, physical, and speech which are limited to 30 units of service within 30 days of an inpatient discharge from a hospital
Providers can perform certain home health services without PA following IHCP member discharge from a hospital

- Providers should use occurrence code 42 with the corresponding date of discharge in the occurrence code and occurrence date fields on the claim form, to bypass PA requirements associated with the preceding parameters
- 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
Home Health Care Billing

• **Single Dates of Service Billing**
  – Providers must bill each date of service as a separate line item
  – Bill each level of service provided on the same date as a separate line item

The procedure code description defines the unit of service

• **Multiple-Visit Billing**
  – When billing for multiple visits, providers should:
    • Verify services are the same prior-authorized services to a member during one day
    • Bill all visits on the same claim form
    • Include total number of units of service provided
Home Health Care Billing

• Overhead Rates
  – Providers may report only one overhead per provider, per member, per day
  – When more than one member of a single household is receiving home health services, from the home health agency during an encounter, only one overhead may be billed.

• If the dates of service billed are consecutive, and one encounter was provided every day, enter occurrence code 73 and the dates of service being billed
Examples:

• Food, housing, homemaker services and home delivered meals
• Home or Outpatient hemodialysis services as such services are Covered under Therapy Services
• Helpful environmental materials such as hand rails, bath stools ramps, telephones, air conditioners, and similar services, appliances and devices
• Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider
• Services provided by a member of the patient’s immediate family
What is Hospice Care?

• Hospice programs are primarily for the treatment of terminal illness and related conditions

• The hospice provider’s responsibilities include:
  – Coordinating the plan of care
  – Ensuring that the plan of care is consistent with the hospice philosophy of care
Managed Care Coordination

• The role of MDwise Medical Management is to:
  – Work with the long-term care facility to ensure timely submission of the request for a Pre-Admission Screening Resident Review (PASRR)
  – Provide the IHCP provider with any nursing facility information required to complete the hospice election form
  – Coordinate care for members that are transitioning into a Home- and Community-Based Services (HCBS) waiver until the disenrollment is effective

• MDwise Medical Management must coordinate care for its members that are transitioning into long-term institutional care, Hospice or a home and community-based waiver services
Hospice Care

Hospice Provided in the Home

Routine and continuous home hospice care may be provided in a member’s home

- Members Home can mean any of the following:
  - Member’s private residence
  - Family member’s residence where patient resides
  - Hospice residence
  - Assisted living facility
  - Adult foster care
  - Residential care facility
  - Nursing facility
Hospice Care

Hoosier Healthwise Members

Members who qualify for such care are disenrolled from the Managed Care Entity (MCE) according to member disenrollment criteria and policies and procedures

- Hoosier Healthwise members who qualify for hospice care are moved to Traditional Medicaid to continue care
- Disenrollment is necessary for hospice authorization to be completed
- Members become eligible for hospice services the business day following disenrollment from the MCE
Hospice Care

Healthy Indiana Plan

- Hospice is a covered benefit for Healthy Indiana Plan members
- Hospice providers have certain responsibilities when a HIP member presents for hospice care, including:
  - Checking eligibility on a regular basis, keeping in mind that eligibility can change daily
  - Identifying the HIP member’s insurance plan and MDwise Delivery System
Private Home Routine Hospice Care

- Revenue Code 651
  - Services are payable for the hospice care at the routine home care rate for each day the member is at home, under the care of the hospice provider, and not receiving continuous home care
  - This rate is without regard to the volume or intensity of routine home care services on any given day
  - One day equals one unit of service
Continuous Home Care in a private home

- Revenue Code 652
  - A period of crisis occurs when a patient requires continuous care, primarily nursing care, to achieve palliation and management of acute medical symptoms
  - The provider must provide a minimum of eight (8) hours of care during a 24-hour day that begin and ends at midnight
  - An RN or LPN must provide care for more than half the total time
  - Less skilled care needed continuously to enable the member to remain at home is covered as routine home care
  - Divide the continuous home care per diem rate by 24 hours to calculate an hourly rate. For every hour or part of an hour of continuous care furnished, this reimburses the hourly rate to the hospice provider, up to 24 hours a day.
Routine home care in a Nursing Facility

- Revenue Code 653
  - IHCP pays:
    - the hospice provider at the routine home care rate for each day the member is in a nursing facility under the care of the hospice provider and not receiving continuous home care
    - this rate without regard to the volume or intensity of routine home care services on any given day
    - the hospice provider 95% of the lowest nursing facility per diem to cover room and board costs incurred by the contracted nursing facility
  - Nursing facility room and board are not billable for the date of death
  - Providers also cannot bill for nursing facility room and board for the date the member is physically discharged from the nursing facility
  - One day equals one unit of service
Routine home care in a Nursing Facility

- Revenue Code 654
  - As in the private home setting, divide the continuous home care rate by 24 hours to calculate an hourly rate. For every hour or part of an hour of continuous care furnished, the IHCP reimburses the hourly rate to the hospice provider, up to 24 hours a day.
  - All limitations listed for the private home setting also apply in the nursing facility setting.
  - One hour equals one unit of service.
Hospice Prior Authorization

Hoosier Healthwise

Hospice authorization starts the date after the member is disenrolled from managed care

• Hospice providers must submit the hospice election form to the PA Department of Cooperative Managed Care Services (CMCS) to coordinate the disenrollment of a hospice member from managed care

• The corresponding Medicaid Hospice Physician Certification form and Medicaid Hospice POC form must be sent to the PA Department of CMCS within ten (10) business days

• CMCS preferred method for providers to submit PA requests is by faxing to 1-800-689-2759
Healthy Indiana Plan

- Prior Authorization is required:
  - Hospice providers submit the request for hospice authorization for a Healthy Indiana Plan member to MDwise
  - All prior authorization requests must be submitted to the member’s assigned MDwise Delivery System
  - Documentation required for PA include:
    - Universal IHCP Prior Authorization form
    - Clinical documentation regarding the member’s diagnosis and prognosis
Tools and Resources

- IHCP Provider Modules

- MDwise Provider Manuals

- MDwise Provider Forms
  - [http://www.mdwise.org/for-providers/forms/](http://www.mdwise.org/for-providers/forms/)

- MDwise Provider Relations Territory Map