

Anthem Blue Cross and Blue Shield (Anthem) Home Health overview

Serving Hoosier Healthwise, Hoosier Care
Connect and Healthy Indiana Plan

September 2016



Agenda

- Eligibility
- Benefit
- Prior authorization
- Billing
- Rates/reimbursement
- Provider operations manual
- Top denials
- Network territory map
- Q&A

Eligibility

Hoosier Healthwise (HHW) options for this program include:

- Package A: Standard (children, transitional low-income parents/caretakers and pregnant women)
- Package C: Children's health plan (children under age 19)
- Package P: Presumptive eligibility (presumptive eligibility for pregnant women)

Please note:

- Healthy Indiana Plan (HIP) includes hospital presumptive eligibility members
- HIP: Basic/State Plan Basic and Plus/State Plan Plus options
- Hoosier Care Connect (HCC) includes the aged, blind, disabled, and some wards and foster children
 - These members are not included in the new Anthem-Franciscan accountable care organization (ACO) contract and remain the financial responsibility of Anthem

Eligibility (cont.)

Each prefix allows member claims to route to the appropriate claims processing center for the product type. It is important to use the correct prefix for your member's plan in order to ensure your claims adjudicate properly.

- Members ages 0-18 enrolled in HHW will use the YRH prefix
- Members ages 19-64 enrolled in HIP will use the YRK prefix
- HCC members will use the YRH prefix

Coverage lasts for one year, and then the member must redetermine eligibility.

Eligibility (cont.)

Always verify a member's eligibility prior to rendering services. Providers can access this information by visiting:

- <https://interchange.indianamedicaid.com> or
- Availability via www.anthem.com/inmedicaiddoc (PMP verification only)

Failure to check eligibility could lead to claim denials.

You will need:

- HHW ID card (issued by the state), or
- The HHW ID card issued to members by Anthem
- **Always** include the 'YRH' prefix before the member's recipient identification (RID) number when filing claims and inquiries

Effective February 19, 2016, providers can check eligibility using the appropriate prefix (for example, for HHW and HCC, use "YRH" and for HIP and hospital presumptive eligibility, use "YRK") **and** the member's recipient identification number.

Home Health benefit

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 (PA)
- A copy of the current plan of treatment developed by the attending physician, therapists, and agency personnel and signed by the attending physician must also be included with the PA request for Home Health services per the Indiana Health Coverage Programs (IHCP) Provider Reference Module for Home Health Services

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.

Anthem requires that Home Health providers call us with the notification of the delivery code of 50 services to begin the care coordination process.

Use occurrence code 50 and hospital discharge date in fields 31-34, a-b.

Prior authorization

Requesting prior authorization 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*

Prior Authorizations: Utilization Management (UM), Pharmacy

Home Health services are covered by Anthem

- Anthem is responsible for furnishing Home Health services
- All Home Health services require PA for both providers who are contracted with Anthem and providers who are not contracted with Anthem
- Contact Anthem Utilization Management via phone to request PA:
 - HHW & HCC phone: **1-866-408-7187**
 - HIP phone: **1-866-398-1922**
 - Fax: **1-866-406-2803**
- Additional information related to obtaining PA maybe found at **www.anthem.com/inmedicaiddoc** either in the provider operations manual or PA sections
- Failure to obtain PA may result in denied claims

Billing

HIP, HHW and HCC

- All Home Health providers must be IHCP-enrolled providers
- Anthem follows IHCP billing guidelines for Home Health claim submission and adjudication
- See Home Health provider reference module at **<http://provider.indianamedicaid.com/general-provider-services/provider-reference-materials.aspx>**.
- Submit all claims on a *UB-04 Claim* form or 837I electronic transaction
- Bill for days approved by the Anthem UM unit

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

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

Overhead

- For each encounter at home, Home Health providers receive an overhead rate for administrative costs.
- 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.
- 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: Plan ahead. Providers are limited to four spans on claim submissions.

UB-04 paper claim

31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE CODE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH	

Occurrence code 61 and individual dates

Occurrence code 61 and date span



Rates DOS

July 1, 2015 to June 30, 2016

*Table 1 – Home health rates for SFY 2016
effective for “from” DOS of July 1, 2015, though June 30, 2016*

Cost/procedure code	Billing unit	95% of median	Less 3%	Rate
Overhead	One unit per provider per recipient per day	\$30.54	(\$0.92)	\$29.62
Registered Nurse (RN) – 99600 TD	Hourly	\$43.34	(\$1.30)	\$42.04
Licensed Practical Nurse (LPN) – 99600 TE	Hourly	\$27.82	(\$0.83)	\$26.99
Home Health Aide – 99600	Hourly	\$18.88	(\$0.57)	\$18.31
Physical Therapist – G0151	15-minute increments	\$17.45	(\$0.52)	\$16.93
Occupational Therapist – G0152	15-minute increments	\$17.19	(\$0.52)	\$16.67
Speech Pathologist – G0153	15-minute increments	\$18.48	(\$0.55)	\$17.93

HHW, HCC and HIP reimbursement

- Providers must refer to their contract, which outlines reimbursement terms
- HHW and HCC
 - 100% of the current Indiana Medicaid fee schedule
- HIP
 - 100% of the current Indiana Medicare fee schedule or 130% of the current Indiana Medicaid fee schedule

Provider Operations Manual (POM)

Navigation

- Visit www.anthem.com/inmedicaiddoc
- Select **Provider Support**
- Choose **Manuals, Training & more**
- Expand the **Indiana Medicaid Provider Manual** menu
- Select *Provider Manual*
- See chapter 11, page 141

Questions?

www.anthem.com/inmedicaidoc

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and Hoosier Care Connect