INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Home- and Community-Based Services Billing Guidelines

Note: For updates to the information in this module, see the following Indiana Health Coverage Programs (IHCP) bulletin, accessible from the IHCP Bulletins webpage at in.gov/medicaid/providers:

- *BT2025121 – IHCP Portal Institutional Level of Care and Hospice panel update available Sept. 25*

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1.1	Policies and procedures as of Sept. 1, 2016 (*Core*MMIS updates as of Feb. 13, 2017) Published: May 16, 2017	Scheduled update	FSSA and HPE
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Version	Date	Reason for Revisions	Completed By
		• Updated the *Eligibility Verification* section • Updated the *Eligibility Verification for 1915(c) HCBS Waiver and MFP Demonstration Grant Benefits* section and subsections, including adding the *PathWays Managed Care Coverage and MCE Assignment* subsection • Updated the *HCBS Billing Instructions* section • Updated the *Waiver Providers Use Provider ID to Bill HCBS Waiver Claims* section • Updated the *Third-Party Liability Exemption* section • Updated the *Claim Completion for 1915(c) HCBS Waiver Services with PathWays* information	
7.1	Policies and procedures as of July 1, 2024 Published: Aug. 27, 2025	Interim update: • Added note on title page pointing to *IHCP Bulletin BT2025121*	FSSA and Gainwell

Table of Contents

Home- and Community-Based Services Billing Guidelines

Note: For updates to the information in this module, see IHCP Bulletins at in.gov/medicaid/providers.

Introduction

To enable individuals who qualify for institutional placement to receive services in their homes and community settings, the Indiana Health Coverage Programs (IHCP) offers the following:

- 1915(c) Home- and Community-Based Services (HCBS) waiver benefits
- 1915(i) HCBS State Plan benefits
- Money Follows the Person (MFP) demonstration grant benefits

These HCBS and demonstration grant benefits are provided through the following divisions of the Indiana Family and Social Service Administration (FSSA):

- Division of Aging (DA)
- Division of Disability and Rehabilitative Services (DDRS)
- Division of Mental Health and Addiction (DMHA)
- Office of Medicaid Policy and Planning (OMPP)

For general information on the HCBS programs offered through these divisions, see the *Home- and Community-Based Services* page at in.gov/medicaid/providers. For information about the MFP demonstration grant, see the *Money Follows the Person* page at in.gov/fssa/da.

The Family and Social Services Administration (FSSA) is the single state agency that serves as the umbrella for the DA, DDRS, DMHA and OMPP. Under the direction of the Secretary of FSSA, the OMPP is responsible for administrative oversight of the HCBS and MFP benefit plans, and all four divisions are charged with day-to-day operation of the HCBS and MFP benefits.

The 1915(c) HCBS waiver, 1915(i) HCBS State Plan and MFP demonstration grant benefit plans are funded with state and federal dollars and are approved by the Centers for Medicare & Medicaid Services (CMS) for a specified time.

1915(c) HCBS Waiver Benefit Plans

Section 1915(c) of the *Social Security Act* permits states to offer, under a waiver of statutory requirements, an array of home- and community-based services that an individual needs to avoid institutionalization. The term *waiver* refers to the fact that the IHCP waives certain requirements applicable to Traditional Medicaid eligibility for individuals who qualify for services through a 1915(c) HCBS benefit plan.

The IHCP offers the following 1915(c) HCBS waiver benefit plans:

- Operated by the DDRS:
  - **Community Integration and Habilitation (CIH) Waiver**
  - **Health and Wellness (H&W) Waiver**
  - **Family Supports Waiver (FSW)**
  - **Traumatic Brain Injury (TBI) Waiver**
- Operated by the OMPP:
  - **Indiana PathWays for Aging (PathWays) Waiver**

> *Note: Prior to July 1, 2024, the IHCP offered an Aged and Disabled (A&D) Waiver, operated by the Division of Aging (DA). That waiver has now been split (according to participant age) into two separate waivers: the H&W Waiver operated by the DDRS, and the PathWays Waiver operated by the OMPP.*
>
> *Also effective July 1, 2024, operation of the TBI Waiver shifted from the DA to the DDRS. Provider certification for the PathWays, H&W and TBI Waivers is now handled by the OMPP. The DDRS continues to handle provider certification for the FSW and CIH Waiver.*

- All potential participants in the DDRS-operated 1915(c) HCBS waivers (CIH, FSW, H&W and TBI) must first be enrolled in the **Traditional Medicaid** fee-for-service (FFS) program.
- Participants in the OMPP-operated PathWays Waiver must first be enrolled in the **Indiana PathWays for Aging** managed care program (or, optionally, for certain groups as described in the following note, in Traditional Medicaid).

> *Note: Certain populations who meet eligibility criteria for PathWays managed care enrollment are instead enrolled in Traditional Medicaid as FFS, unless they opt to enroll in PathWays. This exception applies to individuals who are:*
>
> - *Receiving IHCP hospice services at the time they become eligible for PathWays*
> - *Receiving Personal Directed Home Care services*
> - *Recognized as American Indian or Alaskan Native*
>
> *If such an individual is approved for PathWays Waiver ~~s~~services, those benefits will be provided as FFS.*

If an individual qualifies for a waiver plan but does not meet income requirements for Traditional Medicaid/PathWays, they may be enrolled with a *waiver liability* – a financial obligation that they must meet each month before reimbursement for the waiver services begins. See the *HCBS Waiver Liability* section for details.

For more information about eligibility and services associated with each HCBS waiver benefit plan, see the following modules:

- *Division of Disability and Rehabilitation Services Home- and Community-Based Services Waivers*
- *Office of Medicaid Policy and Planning Home- and Community-Based Services: Indiana PathWays for Aging Waiver*

> *Note: The DA and DDRS also operate the Money Follows the Person (MFP) demonstration grant benefit plans corresponding to the CIH and H&W waiver plans. MFP is a program that serves eligible members as they transition into the appropriate 1915(c) HCBS waiver benefit plan. See the Money Follows the Person Demonstration Grant section of this document for more information.*

1915(i) HCBS Benefit Plans

Section *1915(i)* of the *Social Security Act* gives states the option to offer a wide range of HCBS benefits to members through state Medicaid plans. Using this option, states can offer services and supports to target groups of individuals – including individuals with serious mental illness (SMI), emotional disturbance or substance use disorders – to help them remain in the community.

The IHCP offers the following 1915(i) HCBS benefit plans, operated by the DMHA:

- **Adult Mental Health Habilitation (AMHH)** – The AMHH benefit plan provides services to adults with SMI or substance use disorder who may most benefit from keeping or learning skills to maintain a healthy, safe lifestyle in community-based settings.
- **Behavioral and Primary Healthcare Coordination (BPHC)** – The BPHC benefit plan consists of the coordination of behavioral health and healthcare services to manage the healthcare needs of eligible members. This benefit plan includes logistical support, advocacy and education to assist individuals in navigating the healthcare system, as well as activities that help members gain access to physical and behavioral health services needed to manage their health condition.
- **Child Mental Health Wraparound (CMHW)** – The CMHW benefit plan delivers individualized services to children with serious emotional disturbances (SED). The focused nature of the CMHW benefit plan is intended to better address the special needs of children and youth with SED.

All potential 1915(i) HCBS benefit participants must be enrolled in an IHCP Medicaid program; the allowable *type* of IHCP Medicaid program varies based on the requirements of the specific 1915(i) HCBS benefit plan. (*Note that services provided under a 1915(i) HCBS program are carved out of the managed care delivery system and reimbursed as fee-for-service.*) In addition, some members might be concurrently enrolled in multiple 1915(i) HCBS benefit plans, such as AMHH and BPHC. Some members receiving a 1915(i) HCBS benefit might also receive a 1915(c) HCBS waiver, but must not duplicate services. See the *HCBS Benefit Combinations* section.

Eligibility criteria for AMHH, BPHC and CMHW vary based on the following:

- Income
- Age
- Total scores on the Adult Needs and Strengths Assessment (ANSA) or Child and Adolescent Needs and Strengths (CANS) assessment tool
- Level-of-need (LON) evaluations

For more information about eligibility and services associated with specific 1915(i) HCBS benefit plans, see the following provider modules:

- *Division of Mental Health and Addiction Adult Mental Health Habilitation Services*
- *Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Service*
- *Division of Mental Health and Addiction Child Mental Health Wraparound Services*

Money Follows the Person Demonstration Grant Benefit Plans

The MFP program is funded through a federal grant from the CMS. Indiana's MFP program is specifically designed as a transition program to assist individuals who live in qualifying institutions to move safely into the community and to ensure a safe adjustment to community living.

MFP serves eligible members for up to 365 days, until they transition into the 1915(c) HCBS waiver that the grant is mirrored after. MFP supports the following benefit plans:

- MFP CIH
- MFP H&W

All potential MFP demonstration grant participants must be enrolled in the IHCP Traditional Medicaid program.

The DDRS is responsible for monitoring and reporting to the CMS for all MFP plans.

For more information about the MFP program, see the *Money Follows the Person* page at in.gov/fssa/da.

HCBS Benefit Combinations

Members can be enrolled in multiple HCBS benefit plans at the same time, but services must not be duplicated. The following list shows the combinations of concurrent HCBS benefit plan enrollments that are possible for an eligible member:

- AMHH + BPHC
- CIH Waiver + AMHH
- CIH Waiver + AMHH + BPHC
- CIH Waiver + BPHC
- FSW + AMHH
- FSW + BPHC
- FSW + AMHH + BPHC
- PathWays Waiver + AMHH
- PathWays Waiver + BPHC
- PathWays Waiver + AMHH + BPHC
- H&W Waiver + AMHH
- H&W Waiver + BPHC
- H&W Waiver + AMHH + BPHC
- H&W Waiver + CMHW
- TBI Waiver + AMHH
- TBI Waiver + BPHC
- TBI Waiver + AMHH + BPHC
- TBI Waiver (nursing facility level of care only) + CMHW

Note: A member cannot be enrolled in two 1915(c) HCBS waiver benefit plans at the same time.

Providers must have a thorough knowledge of the OMPP, DDRS and DMHA provider reference modules, as well as the *Member Eligibility and Benefit Coverage* module, to be able to determine eligibility for possible IHCP Medicaid, 1915(c) HCBS waiver and 1915(i) HCBS benefit plan and service combinations.

Authorization of Services

Services provided under an HCBS program or MFP demonstration grant must be authorized as described in the following sections. Service authorization information, detailing the specific services approved, is provided to the participant (or guardian) and the participant's providers.

Authorization of 1915(c) HCBS Waiver and MFP Demonstration Grant Services

For 1915(c) HCBS waiver and MFP demonstration grant participants, the HCBS case or care manager (or the managed care entity [MCE] service coordinator, in the case of the PathWays managed care members) is responsible for completing a service plan or plan of care/cost comparison budget (POC/CCB), which, when approved, results in a service authorization with the following information:

- Approved date period
- Name of the authorized provider
- Each waiver service approved for the participant, including:
  - Billing code with the appropriate modifiers
  - Number of units or dollars to be provided

This service authorization information is then sent to the provider and member on either a Notice of Action (NOA) or a Service Authorization form (depending on the waiver).

For fee-for-service (FFS) members, this data is transmitted to the Core Medicaid Management Information System (*Core*MMIS) and stored in the prior authorization database. For PathWays members, the MCE stores this data within their own claim-processing system. Claims deny if no authorization exists in the appropriate database or if a procedure code-modifier combination other than those approved is billed. (See the *Procedure Codes and Modifiers* section for details, including an exception to this rule.)

Providers must not render or bill HCBS waiver or MFP demonstration grant services without an approved NOA or Service Authorization form. It is the responsibility of each provider to contact the case or care manager (or MCE service coordinator) in the event the services, as authorized or rendered, do not meet the definition and parameters of the approved services on the NOA or Service Authorization form. If the needs of a member change, the provider must contact the case or care manager (or MCE service coordinator) to discuss revising the service plan or POC/CCB.

For additional information about authorization of HCBS waiver services, see the following modules:

- *Division of Disability and Rehabilitation Services Home- and Community-Based Services Waivers*
- *Office of Medicaid Policy and Planning Home- and Community-Based Services: Indiana PathWays for Aging Waiver*

Authorization of 1915(i) HCBS Benefit Plan Services

The authorization process for 1915(i) HCBS program services varies by benefit plan:

- Authorization for AMHH services – AMHH applications are submitted through Data Assessment Registry Mental Health and Addiction (DARMHA). After an applicant is determined eligible for AMHH, the DMHA State Evaluation Team (SET) approves specific AMHH services based on review of documentation and the Individualized Integrated Care Plan (IICP). This approval is transmitted to the IHCP, and an AMHH Service Authorization form is sent to the applicant and the applicant's provider. Providers may bill only for those services that were authorized. An eligible AMHH member is authorized to receive AMHH services on an approved IICP for one year (360 days) from the start date of AMHH eligibility, or as determined by the SET. Services may be provided according to the DMHA-approved IICP as long as the member continues to meet AMHH eligibility criteria. For additional authorization information, see the *Adult Mental Health Habilitation Services* page at in.gov/fssa/dmha and the *Division of Mental Health and Addiction Adult Mental Health Habilitation Services* module.
- Authorization for BPHC service – BPHC applications are submitted through DARMHA. The SET transmits the BPHC benefit plan and service approval to the IHCP, and a BPHC Service Authorization form is sent to the applicant and the applicant's provider. The Service Authorization form generated includes the start and end dates for BPHC eligibility as well as the number of units approved for the BPHC procedure code and modifiers indicated. Providers may bill only for those services that were authorized. For additional authorization information, see the *Behavioral and Primary Healthcare Coordination* page at in.gov/fssa/dmha and the *Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Service* module.
- Authorization for CMHW services – CMHW applications are submitted through the Tobi database. After the DMHA deems an applicant eligible for the CMHW benefit plan, the DMHA creates an initial intervention plan that includes two months of wraparound facilitation services. The Wraparound Facilitator works with the family to develop a Child and Family Team that will work together with the participant and family to develop an individualized initial plan of care (POC) and immediate crisis/safety stabilization plan. Until the initial POC is developed by the Child and Family Team and approved by the DMHA, no other CMHW service may be accessed. If the DMHA approves the POC, the approval is transmitted to the IHCP, and a Service Authorization form is sent to the applicant and the applicant's providers. For additional authorization information, see the *Child Mental Health Wraparound (CMHW) Services* page at in.gov/fssa/dmha and the *Division of Mental Health and Addiction Child Mental Health Wraparound Services* module.

See the *Eligibility Verification for 1915(i) HCBS Benefits* section of this module for information about viewing authorized 1915(i) services in the IHCP Provider Healthcare Portal (IHCP Portal).

Eligibility Verification

All IHCP-enrolled providers must verify member eligibility before the initiation of services and on each date of service thereafter, because a member may become ineligible for services at any time.

Providers can access IHCP Eligibility Verification System (EVS) information using the following methods:

- IHCP Provider Healthcare Portal, accessible from the homepage at in.gov/medicaid/providers
- Virtual assistant (GABBY) at 800-457-4584, option 2
- 270/271 Eligibility Benefit Inquiry and Response electronic transactions using approved vendor software

See the *Member Eligibility and Benefit Coverage* module for details about using these eligibility verification methods.

Eligibility Verification for 1915(c) HCBS Waiver and MFP Demonstration Grant Benefits

To verify eligibility for HCBS waiver or MFP demonstration grant services, providers must confirm ***all*** the following for the date of service:

- The member is enrolled in one of the following IHCP programs:
  - Indiana PathWays for Aging (for managed care members with PathWays Waiver benefits)
  - Traditional Medicaid (for all other HCBS waiver or MFP participants)
- The member has an open HCBS waiver or MFP demonstration grant level-of-care status recorded in *Core*MMIS.
- The specific waiver service being provided has been approved for the member.
- The member has met their waiver liability for the month, if applicable. For PathWays Waiver participants (enrolled under managed care), waiver liability information must be confirmed using the applicable MCE's provider portal or other method offered by the MCE. For all the other waiver participants, this information can be checked using the IHCP Portal or other IHCP EVS options

See the following sections for details.

IHCP Enrollment Under Traditional Medicaid FFS or PathWays Managed Care

PathWays Waiver participants must be enrolled in the Indiana PathWays for Aging managed care program (or in the Traditional Medicaid FFS program, if they fall into an exempted group described in the *1915(c) HCBS Waiver Benefit Plans* section and do not opt to enroll in PathWays). All *other* HCBS waiver and MFP demonstration grant participant must be enrolled in the Traditional Medicaid FFS program. Indiana PathWays for Aging is the only managed care program that allows for HCBS waiver benefits.

Providers should verify member eligibility on the 1st and 15th calendar days of the month, because member eligibility in managed care is effective on those days.

Traditional Medicaid Fee-for-Service Coverage

The EVS identifies Traditional Medicaid coverage as either "Full Medicaid" or "Package A – Standard Plan." However, these same benefit plans are also available under certain managed care programs, including Hoosier Care Connect, Hoosier Healthwise and Indiana PathWays for Aging. Therefore, to determine whether the member is enrolled under Traditional Medicaid, providers must *also* confirm that the coverage is fee-for-service. On the IHCP Portal, this information appears in the *Managed Care Assignment Details* panel (see Figure 1).

Figure 1 – IHCP Portal Managed Care Assignment Details Panel for a Traditional Medicaid Member

Managed Care Assignment Details

Managed Care Program		Primary Medical Provider	Provider Phone
Fee for Service + NEMT			
Effective Date	**End Date**	**MCO / CMO Name**	**MCO / CMO Phone**
05/05/2023	05/05/2023	VERIDA, INC	

> *Note: Although Traditional Medicaid is a fee-for-service program, most nonemergency medical transportation (NEMT) services provided under Traditional Medicaid are subject to brokerage requirements, as described in the Transportation Services module. For this reason, the EVS may indicate Traditional Medicaid coverage as fee-for-service plus NEMT, and list the NEMT broker (Verida) as a managed care entity (MCO/CMO).*
>
> *Keep in mind that, while Traditional Medicaid NEMT services may be subject to brokerage for these members, authorized HCBS waiver transportation services are not subject to brokerage.*

PathWays Managed Care Coverage and MCE Assignment

Most members with PathWays Waiver benefits are enrolled in the Indiana PathWays for Aging managed care program.

The EVS identifies Indiana PathWays for Aging coverage as "Full Medicaid," with a managed care program assignment of "Indiana PathWays for Aging." It also indicates the name of the MCE responsible for administering that member's benefits. (*Note that "managed care organization" [MCO] and "care management organization" [CMO] are alternative terms for MCE.*)

Figure 2 – IHCP Portal Managed Care Assignment Details Panel With MCE Assignment for a PathWays Member – Example

Managed Care Assignment Details

Managed Care Program		Primary Medical Provider	Provider Phone
Indiana Pathways for Aging			
Effective Date	**End Date**	**MCO / CMO Name**	**MCO / CMO Phone**
05/16/2024	05/16/2024	HUMANA HEALTHY HORIZONS	1-866-274-5888

> *Reminder: Certain PathWays Waiver members may be enrolled under Traditional Medicaid, if they fall into an exempted group as described in the 1915(c) HCBS Waiver Benefit Plans section.*

HCBS Waiver or MFP Demonstration Grant Coverage

The EVS identifies HCBS waiver coverage using one of the following benefit plan names:

- Aged and Disabled HCBS Waiver – *Denotes Health and Wellness (H&W) Waiver coverage*
- Aged and Disabled HCBS PathWays – *Denotes Indiana PathWays for Aging (PathWays) Waiver coverage*
- Community Integration and Habilitation HCBS Waiver – *Denotes CIH Waiver coverage*
- Family Supports HCBS Waiver – *Denotes FSW coverage*
- Traumatic Brain Injury HCBS Waiver – *Denotes TBI Waiver coverage*

The EVS identifies MFP demonstration grant coverage using one of the following benefit plan names:

- MFP Community Integration and Habilitation – *Denotes Money Follows the Person (MFP) CIH coverage*
- MFP Demonstration Grant HCBS Waiver – *Denotes MFP H&W coverage*

To qualify for waiver or MFP demonstration grant coverage, members must meet the requirements for an institutional level of care (LOC) – either nursing facility (NF) or, for certain waivers or MFP plans, intermediate care facility for the individuals with intellectual disabilities (ICF/IID).

> *Note: Gainwell Technologies cannot add or correct a level-of-care segment in CoreMMIS (or corresponding benefit plan in the EVS) for waiver of MFP coverage. Providers may contact the INsite Helpdesk at insite.helpdesk@fssa.in.gov to initiate corrections to a level-of-care segment for FFS HCBS waiver or MFP demonstration grant.*

In the IHCP Portal, this coverage is listed in the *Benefit Details* panel during eligibility verification. See Figure 3 for an example of a member with FSW coverage for the date indicated.

Figure 3 – Portal Benefit Details Example With HCBS Waiver Coverage

Benefit Details

Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	07/02/2024	07/02/2024
Qualified Medicare Beneficiary	Qualified Medicare Beneficiary - Members for whom co-insurance and deductibles are paid as well as Medicare Part B premiums	07/02/2024	07/02/2024
Family Supports HCBS Waiver	Authorized Family Supports HCBS Waiver services found in the Notice of Action (NOA)	07/02/2024	07/02/2024

HCBS Waiver Liability

Members with an HCBS waiver liability are responsible for payment of all waiver services until they have met their waiver liability for the month. Until this monthly obligation has been met, their HCBS waiver (H&W, PathWays, TBI, CIH or FSW) services are not reimbursable by the IHCP.

When verifying member eligibility on the IHCP Provider Healthcare Portal, providers should look for the *Waiver Liability Details* panel. If the panel is not included in the eligibility results, the member is not subject to a monthly liability. If the panel is included, clicking the plus-sign (+) will expand the panel to reveal additional information:

- For FFS members with a waiver liability, the IHCP Portal will display the monthly liability obligation amount and the balance that remains due for the month (see Figure 4). This information is also available from the phone-based virtual assistant (GABBY) and from the 270/271 electronic data transaction.
- For PathWays managed care members with a waiver liability, the IHCP Portal will alert providers to contact the member's MCE for liability information, including the monthly waiver obligation amount and the balance remaining for that month (see Figure 5). See the *IHCP Quick Reference Guide* for the PathWays MCE provider portal links and provider services contact information.

If a member has a waiver liability with a balance remaining, the provider should render the service and bill the IHCP as usual. After the claim is processed, the provider may then bill the member for any zero-paid amount that was credited toward the member's monthly liability.

Figure 4 – IHCP Portal Waiver Liability Details for FFS Member With a Waiver Liability

Waiver Liability Details

These amounts are based on claims processed at the time of this eligbility verification. It is subject to change at any time follwoing this eligibility verification as claims continue to process in the system. A provider may bill a member for the Waiver Liability amount deducted from teh adjudicated claim; however, with the exception of point of sale (POS) pharmacy claims, the membre is not required to pay the provider until the member receives the monthly Medicaid Waiver Liability Summary Notice listing the amount applied ot Waiver Liability.

Month	Waiver Liability Obligation	Waiver Liability Balance
November, 2017	$100.00	$76.37

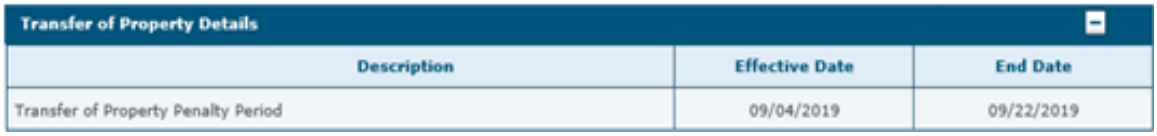
Figure 5 – IHCP Portal Waiver Liability Details for a Managed Care PathWays Member With a Waiver Liability

Transfer of Property Detail

Some members incur a transfer of property penalty while they are transferring assets. During this period, claims for HCBS waiver services will be denied.

Providers enrolled as waiver providers (type 32) will see the *Transfer of Property Detail* panel if the member is ineligible for coverage of waiver services on the dates searched due to a transfer of property penalty period.

Figure 6 – Transfer of Property Detail



Authorized Waiver Services

Providers must refer to the NOA or Service Authorization form for information about specific services approved for the member's HCBS waiver or MFP demonstration grant. See the *Authorization of Services* section for details.

Eligibility Verification for 1915(i) HCBS Benefits

Members must be enrolled in the Traditional Medicaid program, *HIP State Plan Plus*, *HIP State Plan Basic*, *HIP Maternity*, Hoosier Healthwise, Hoosier Care Connect or Indiana PathWays for Aging to be eligible for 1915(i) HCBS benefits. For these members, the EVS indicates coverage as both the applicable IHCP Medicaid benefit plan as well as the 1915(i) HCBS benefit plan.

The EVS identifies 1915(i) HCBS coverage using following benefit plan names:

- Adult Mental Health Habilitation
- Behavioral & Primary Healthcare Coordination
- Child Mental Health Wraparound

> *Note: As described in the HCBS Benefit Combinations section, a member may have coverage from multiple 1915(i) HCBS benefit plans simultaneously, and a member may have 1915(c) HCBS waiver coverage at the same time as 1915(i) HCBS coverage as long as there is not a duplication of services.*

Figure 7 shows IHCP Portal eligibility verification with coverage details for a member who has AMHH coverage.

Figure 7 – IHCP Portal Benefit Details Example With 1915(i) HCBS Coverage

Benefit Details

Coverage	Description	Effective Date	End Date
Adult Mental Health Habilitation	Authorized adult Mental Health Habilitation services found in the Notice of Action (NOA)	02/14/2020	02/14/2020
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	02/14/2020	02/14/2020

If the provider performing the IHCP Portal eligibility verification is an AMHH, BPHC or CMHW provider, the 1915(i) HCBS benefit plan name will appear as a hyperlink in the *Benefit Details* panel (Figure 7). The provider can click the benefit plan name to view the *Detail Information* panel, which shows the specific services that have been authorized for the member under that benefit plan (Figure 8).

Figure 8 – IHCP Portal Detail Information for an AMHH Member

Detail Information

Total Records: 3

Provider	Code	Description	Service Dates	Units Authorized	Units Used	Amount Authorized	Amount Used
PROVIDER NAME	H2014 UB	SKILLS TRAIN AND DEV, 15 MIN	07/07/2019 - 07/01/2020	2920	879	-	$22,977.06
PROVIDER NAME	T1016 UB	CASE MANAGEMENT	07/07/2019 - 07/01/2020	800	67	-	$973.51
PROVIDER NAME	H0034 UB	MED TRNG & SUPPORT PER 15MIN	07/07/2019 - 07/01/2020	728	23	-	$428.26

The *Detail Information* panel lists each service that has been authorized for that member under the 1915(i) HCBS benefit plan selected, including the following information:

- **Provider** – Practitioner or entity that requested the PA
- **Code** – Procedure code and modifiers for the approved service
- **Description** – Description of the approved service
- **Service Dates** – The effective date range of the HCBS service package (*Note: Services rendered prior to the start date or after the end date are not considered for reimbursement.*)
- **Units Authorized** – The number of units that are approved for this service
- **Units Used** – The number of units of this service that have been used
- **Amount Authorized** – The dollar amount that is approved for this service
- **Amount Used** – The dollar amount of this service that has been used

> *Note: The information displayed for Units Used and Amount Used is based on paid claims only.*

The *Detail Information* panel is available only for 1915(i) HCBS and Medicaid Rehabilitation Option (MRO) benefit plans. For information about services authorized for 1915(c) HCBS waiver or MFP benefit plans, providers must consult the member's NOA or Service Authorization form.

Electronic Visit Verification

In accordance with federal requirements, the IHCP has implemented an electronic visit verification (EVV) system for documenting personal care services. Effective for dates of service on or after Jan. 1, 2021, providers are required to use EVV to document all personal care services (procedure code and modifier combinations) indicated in *Service Codes That Require Electronic Visit Verification*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

For certain services, as indicated on the code tables, the EVV requirement is waived if the service is performed in a 24-hour congregate setting. Providers are instructed to use the HQ modifier to indicate when that is the case.

For more information, see the *Electronic Visit Verification* page at in.gov/medicaid/providers.

HCBS Billing Instructions

With the exception of PathWays Waiver services provided to PathWays managed care members, all other HCBS and MFP services should be billed as fee-for-service (FFS) to Gainwell Technologies, using the IHCP Portal professional claim, 837P electronic transaction or *CMS-1500* claim form. For general information about FFS billing of professional claims, see the *Claim Submission and Processing* module. For FFS paper-claim submissions, providers should mail the completed *CMS-1500* claim form, along with any additional required documentation, to the following address:

Gainwell – CMS-1500 Claims
P.O. Box 7269
Indianapolis, IN 46207-7269

> *Note: Gainwell P.O. boxes will be changing, effective Aug. 1, 2024. The new address for FFS professional claims will be:*
>
> **Gainwell – CMS-1500 Claims**
> **P.O. Box 50447**
> **Indianapolis, IN 46250-0418**

For managed care members with PathWays Waiver benefits, waiver services should be billed to the administering managed care entity (MCE). Providers are advised to consult the member's MCE for additional billing guidance. See the *PathWays Managed Care Coverage and MCE Assignment* section for instructions on determining a member's MCE. For mailing addresses and other contact information, see the *IHCP Quick Reference Guide* at in.gov/medicaid/providers.

As described in the *1915(c) HCBS Waiver Benefit Plans* section, PathWays Waiver participants from certain populations may choose not to opt in to managed care and will be enrolled in FFS Traditional Medicaid.

For these individuals, providers should follow the FFS billing process and send the waiver claims to Gainwell Technologies.

Providers are responsible for checking an individual's health plan assignment at least monthly to ensure they submit claims to the correct payor.

> *Note: The IHCP recommends submitting claims electronically. For FFS electronic billing, see the Provider Healthcare Portal and Electronic Data Interchange modules, or contact a Provider Relations consultant for more information. For managed care members, contact the member's MCE for electronic billing options.*
>
> *CMS-1500 paper claims must be submitted on the official red claim forms developed by the National Uniform Claim Committee (NUCC). The IHCP does not accept black-and-white copies.*

The following sections provide additional information specific to HCBS billing.

Procedure Codes and Modifiers

Services provided under the 1915(i) and 1915(c) benefit plans are limited to the procedure code/modifier combinations approved for the individual member. Providers must consult the NOA or Service Authorization form to determine the procedure code/modifier combinations approved to bill for the member under that benefit plan. For AMHH, BPHC and CMHW members, this information can also be seen on the *Detail Information* panel when providers perform eligibility verification through the IHCP Portal, as described in the *Eligibility Verification for 1915(i) HCBS Benefits* section.

Exceptions to the limitation that procedure code/modifier combinations must be authorized on the member's NOA or Service Authorization form include the following:

- Assisted Living service, where the NOA or Service Authorization form authorizes the member for T2031 U7 U1 for the daily rate, but the provider is able to bill T2031 U7 U1 UA for the monthly rate, even though modifier UA is not listed on the NOA or Service Authorization form
- Services that would otherwise require EVV, but for which the EVV requirement is waived because the service was provided in a 24-hour congregate living setting and billed with the HQ modifier appended even though that modifier was not listed on the NOA or Service Authorization form (see the *Electronic Visit Verification* section)
- IHCP-covered coronavirus disease 2019 (COVID-19) vaccine and administration services rendered by a qualified FSW or CIH waiver provider and billed with the appropriate procedure codes plus modifier U7, even though such codes are not listed on the member's Service Authorization form

Units of Service

If a unit of service equals 15 minutes*, a minimum of eight minutes* must be provided to bill for one unit. Activities requiring less than eight minutes may be accrued to the end of that date of service. At the end of the day, partial units may be rounded as follows: units totaling more than eight minutes may be rounded up and billed as one unit. *Partial units totaling less than eight minutes may not be billed.*

Billing With IHCP Provider ID or NPI

The following sections explain which HCBS providers should bill using a National Provider Identifier (NPI) and which HCBS providers should bill using an IHCP Provider ID.

Waiver Providers Use Provider ID to Bill HCBS Waiver Claims

Waiver providers are considered to be atypical providers and must bill claims for HCBS waiver services using the IHCP Provider ID. Waiver providers may also be separately enrolled as a Type 05 (Home Health Agency) provider and would use an NPI when billing services under that provider type.

Example: A provider performs both HCBS waiver and Medicaid home health services. When submitting claims, the home health provider must bill using the NPI and the taxonomy code. The waiver provider bills using the assigned IHCP Provider ID for the Type 32 (Waiver) enrollment. If the waiver claim is billed with the NPI and a taxonomy code, payment is sent to the home health provider.

Providers Use NPI to Bill 1915(i) HCBS Claims

AMHH, BPHC and CMHW providers are considered typical providers and must bill HCBS claims using the NPI.

Third-Party Liability Exemption

The IHCP will not bill private insurance carriers through the third-party liability (TPL) or reclamation processes for claims containing any HCBS benefit modifier codes. This exemption includes service codes (procedure code plus modifier) specific to claims for the following benefit plans:

- AMHH
- PathWays Waiver
- BPHC
- CMHW
- CIH Waiver
- FSW
- H&W Waiver
- MFP CIH
- MFP H&W
- TBI Waiver

Claim Completion for 1915(i) State Plan Services

For 1915(i) State Plan HCBS claims, including claims for AMHH, BPHC and CMHW services, providers follow the general instructions for completing a professional claim.

1915(i) HCBS program services are carved out of the managed care delivery system. Therefore, these services must be billed to Gainwell as fee-for-service claims for **all** members, including those enrolled in a managed care program.

Claim Completion for 1915(c) HCBS Waiver Services

Table 1 lists the required fields for billing HCBS waiver services on the *CMS-1500* claim form. The table provides instructions for each required field. The IHCP strongly advises providers to complete only the designated fields in Table 1 for HCBS waiver billing. Completing fields not listed in the table could result in claim denial. A copy of the *CMS-1500* claim form follows the table (see Figure 9). The PathWays MCEs may require additional fields on the *CMS-1500* claim form to be completed. Please refer to the PathWays MCEs' uniform billing format.

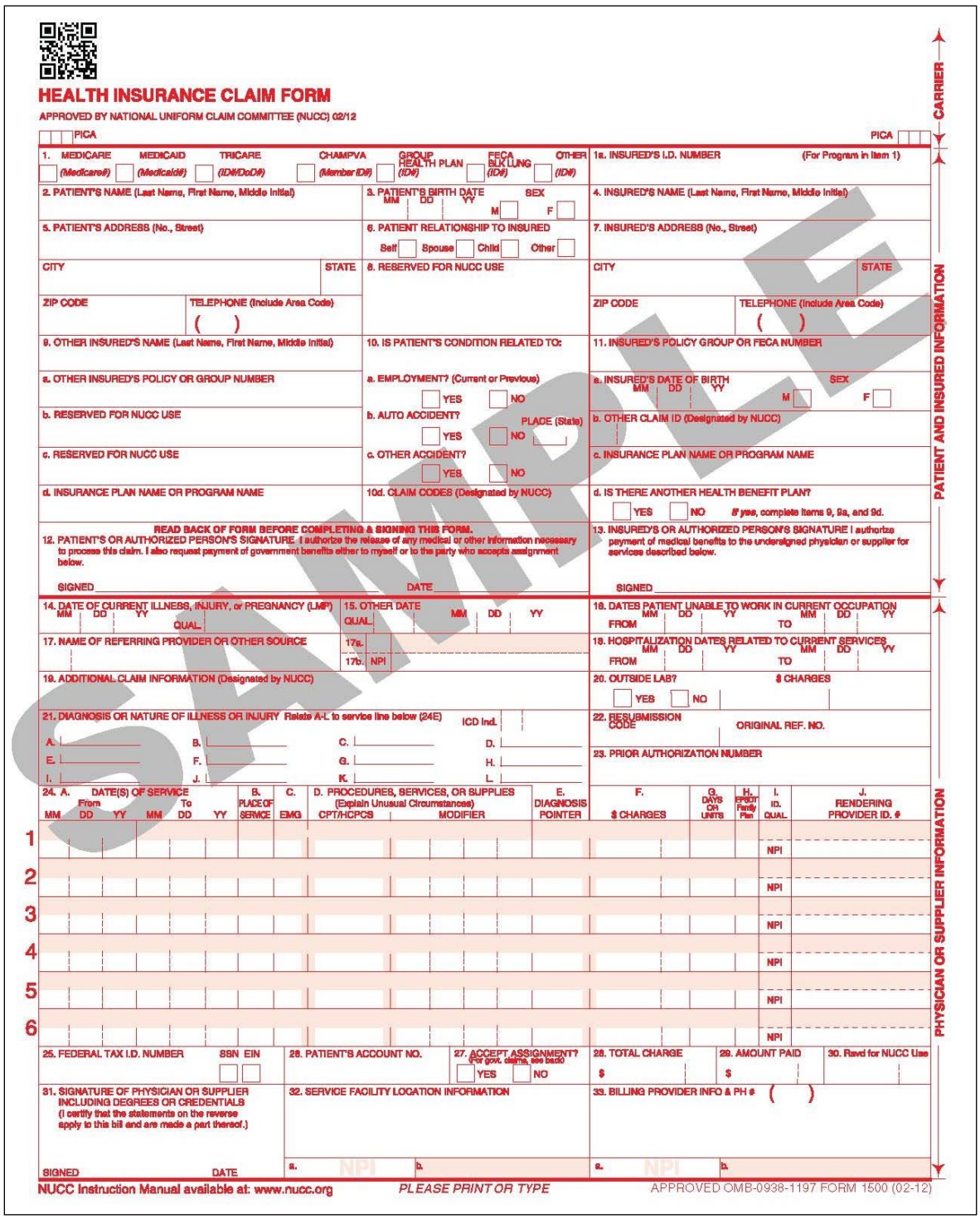
> *Note: The same general instructions as those in the following table also apply to HCBS waiver claims submitted electronically. However, some fields in the IHCP Portal (or equivalent MCE provider portal) may have slightly different names, appear in a different order or require the information be submitted in a different format than on the paper claim form. Additionally, some fields in the IHCP Portal are auto-filled based on provider and member information stored in CoreMMIS. See the Claim Submission and Processing module for more information.*

Table 1 – *CMS-1500* Claim Form Fields for HCBS Waiver Claims

Form Field	Description	Instructions
1	TYPE OF INSURANCE COVERAGE	Enter **X** in the Medicaid box.
1a	INSURED'S I.D. NUMBER	Enter the 12-digit IHCP Member ID.
2	PATIENT'S NAME	Enter the member's last name, first name and middle initial. (The name on the claim must exactly match the name as it appears in *Core*MMIS. Use one of the EVS options described in the *Eligibility Verification* section to confirm correct usage.)
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Enter the name of the waiver case/care manager, *not* a physician's name. (Optional)
17a	[ID NUMBER OF REFERRING PROVIDER OR OTHER SOURCE]	Enter the qualifier **G2** in the first box of field 17a, followed by the case/care manager's IHCP Provider ID, which is listed on the member's NOA or Service Authorization form, in the second box (shaded). (Optional)
21A-L	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	1. Enter the ICD diagnosis codes in priority order. A total of 12 codes can be entered. ➢ If the actual diagnosis code is not known, enter **R69** in field 21, line A, as the diagnosis for all waiver or demonstration grant members. 2. In the ICD Ind. field, enter **0** to indicate ICD-10 diagnosis codes.
24A	DATE(S) OF SERVICE	Enter the month, day and year for the *from* and *to* dates that are applicable to the billing period for each service rendered. • Use the six-digit MMDDYY format. • Always complete the *from* and *to* dates. • Bill consecutive dates of service for the same procedure code and same month on a single line. • Bill multiple months on separate lines.
24B	PLACE OF SERVICE	Enter the appropriate two-digit code from the following list: • 11 – Office/Clinic • 12 – Home
24D	PROCEDURES, SERVICES, OR SUPPLIES	Use *only* waiver service procedure codes and modifiers, as they are shown on the approved NOA or Service Authorization form*. • Place the procedure code in the left side of field 24D under CPT/HCPCS. Enter only one procedure code on each detail line. • Enter the appropriate modifier(s) in the right side of field 24D, under MODIFIER. **See the Procedure Codes and Modifiers section for exceptions.*

Form Field	Description	Instructions
24E	DIAGNOSIS POINTER	Enter **A** referring to field 21 where R69 (or other appropriate diagnosis code) was entered.
24F	CHARGES	Enter the total amount charged for this service, based on the number of units billed in field 24G.
24G	DAYS OR UNITS	Enter the total number of units, in whole units only, for the service date or dates on that line. See the NOA or Service Authorization form for unit duration for each code billed.
24I Top Half – Shaded Area	ID QUAL	Enter qualifier **G2** in this field.
24J Top Half – Shaded Area	RENDERING PROVIDER ID #	Enter the IHCP Provider ID for the provider that rendered the service. The following explains which rendering Provider ID is used, depending on the type of provider billing: • For agencies billing case/care management services, the rendering Provider ID is the case/care manager's Provider ID. • For Area Agencies on Aging (AAA) billing for services other than case management, the rendering Provider ID is the agency's rendering Provider ID issued by the IHCP. • For all group providers, the rendering Provider ID is the agency's rendering Provider ID issued by the IHCP. The rendering Provider ID must be linked to the group Provider ID. • For all sole proprietors or billing providers, the rendering Provider ID is the Provider ID issued by the IHCP to the waiver provider.
24J Bottom Half	RENDERING PROVIDER NPI	Leave this field blank. Waiver providers should not use the NPI.
28	TOTAL CHARGE	Enter the sum of all the amounts (each detail line) in field 24F.
29	AMOUNT PAID	For all HCBS waiver claims, including those members with HCBS waiver liability, always enter **$0**.
31	SIGNATURE OF PHYSICIAN OR SUPPLIER	IHCP participating providers must have a signature on file; therefore, this field is optional.
33	BILLING PROVIDER INFO & PHONE #	Enter the billing provider service location name, address and nine-digit ZIP code.
33a	BILLING PROVIDER NPI	Leave this field blank. Waiver providers should not use the NPI.
33b	[BILLING PROVIDER QUALIFIER AND ID NUMBER]	Enter the qualifier **G2** and the billing provider's IHCP Provider ID.

Figure 9 – Paper *CMS-1500* Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Supporting Documentation

Supportive documentation is required when billing for HCBS benefit plan services. The documentation should include the following:

- Complete date of service, including month, day and year
- Time entry for service provided, including the time in and time out
  - Providers should note a.m. and p.m., as appropriate, unless using 24-hour time notations.
  - Providers should ensure consistent notation of time – standard notation or 24-hour notation
- Number of units of service delivered on that date
- Specific goal on the individual's person-centered plan that the service addressed
- Signature of any staff member providing the service or making entries into the documentation
  - Signature must include a minimum of the first initial and last name
  - Signature must include the staff member's certification or title

> *Note: For service providers that use electronic signatures for documentation, a specific policy **must** be in place specifying how electronic signatures will be established, controlled and verified. For citations specific to documents transmitted to the State, see the following sections of Indiana Code (IC):*
>
> - *Electronic Digital Signatures Act (IC 5-24)*
> - *Uniform Electronic Transactions Act (IC 26-2-8)*
>
> *In addition, the State Board of Accounts has promulgated a rule with additional regulations, which can be found at Indiana Administrative Code 20 IAC 3.*

Providers are required to verify the specifications for documentation standards for all HCBS benefit plans the provider is authorized to operate. See the individual HCBS program modules on the *IHCP Provider Reference Modules* page at in.gov/medicaid/providers for documentation requirements and standards specific to each HCBS benefit plan.

Special Processing for HCBS Provided on Long-Term Care Discharge Dates or During Hospice Level of Care

It is appropriate for transition-related HCBS benefit plan services to be provided on the same day a long-term care (LTC) member discharges. Provision of certain HCBS benefit plan services to members with a hospice level of care may also be appropriate. Payment for services provided under either of these circumstances will be systematically denied unless specially handled.

Providers submitting claims for HCBS benefit plan services on the member's date of discharge from the LTC facility or during a period of hospice level of care should contact their Provider Relations consultant for special claim handling. Providers that have had claims previously denied for situations such as these should also contact their consultant for special handling. To locate the consultant assigned to your area, see the *Provider Relations Consultants* page at in.gov/medicaid/providers.

When using the IHCP Portal to verify eligibility, hospice and LTC level-of-care information appears in the *Institutional Level of Care and Hospice* panel (Figure 10) in the coverage details.

Figure 10 – Institutional Level of Care and Hospice Coverage Details

Institutional Level of Care and Hospice			
Level of Care	**Provider**	**Effective Date**	**End Date**
Nursing Facility Level of Care	PROVIDER NAME	05/28/2020	05/28/2020
Patient Liability/Client Obligation: $1,375.00			

Paid Claim Adjustments

Claim adjustments are necessary when a provider needs to make corrections to a claim that has already been submitted. See the *Claim Adjustments* module for information on submitting adjustments.

HCBS Provider Reimbursement

The IHCP reimburses HCBS providers for covered services they provide to HCBS members using a standard, statewide rate-setting methodology. The FSSA establishes HCBS rates and rate capitations.

To receive appropriate reimbursement, the Medicaid-enrolled HCBS provider must bill only those services (procedure code and modifier combinations) authorized on the approved NOA or Service Authorization form and listed on the member's prior authorization file. (For AMHH, BPHC and CMHW services, providers can also find this information on the *Detail Information* panel when performing eligibility verification on the IHCP Portal.) Providers must ensure that the documentation of the service rendered, and the procedure code and modifiers billed, are in accordance with the service definition and parameters as published in the specific HCBS provider module.

HCBS benefit services cannot be provided in any institutional settings. If a member is admitted to an institutional setting, such as a hospital, nursing facility or correctional facility, an HCBS provider may not render nor receive reimbursement for HCBS benefit plan services while the member is institutionalized. Some exceptions exist under certain circumstances, such as with transition case management or respite services provided in institutional settings. For allowable HCBS settings for benefits, HCBS providers must have a thorough knowledge of the *Indiana Statewide Transition Plan* (available on the *Home- and Community-Based Services Final Rule Statewide Transition Plan* page at in.gov/fssa) as well as the respective OMPP, DDRS and DMHA provider modules:

- *Division of Mental Health and Addiction Adult Mental Health Habilitation Services*
- *Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Service*
- *Division of Mental Health and Addiction Child Mental Health Wraparound Services*
- *Division of Disability and Rehabilitative Services Home- and Community-Based Services Waivers*
- *OMPP Home- and Community-Based Services: Indiana PathWays for Aging Waiver*