Housing Stabilization Services
Provider FAQ

What is the Housing Stabilization benefit?
Housing Stabilization is a Home and Community Based Service (HCBS), and providers of Housing Stabilization services must abide by the HCBS requirements. The goals (outlined by DHS) of Housing Stabilization Services are to: support an individual's transition to housing, increase long-term stability in housing and avoid future periods of homelessness or institutionalization.

How do I identify Medica members eligible for this benefit?
This benefit is available for all Medicaid members. This includes: Medica DUAL Solution® (Minnesota Senior Health Care Options; MSHO), Minnesota Senior Care Plus (MSC+), Medica AccessAbility Solution® (Special Needs Basic Care; SNBC), Medica AccessAbility Solution Enhanced (Special Needs Basic Care Special Needs Plan; SNBC SNP), Medica Choice Care℠ PMAP (Prepaid Medical Assistance Plan).

How do I know if I am an eligible provider for these services?
All providers that would like to provide these services must enroll as a Housing Stabilization Service (HSS) provider with the Minnesota Department of Human Services (DHS). All credentialing requirements are handled at DHS, not Medica. Once enrolled, you will show up on a Provider Enrollment CD (PECD) file that is sent to Medica on the 1st and 15th of each month.

Is authorization required?
Yes. A provider must go through the DHS approval process and through that process, Medica will receive notification of any service approvals or service changes. With this notification, Medica will enter an authorization into our system.

What is the process for obtaining an authorization?
The housing consultation provider or the assigned MSHO/MSC+ Care Coordinator will work with the member to develop a plan and submit to a DHS enrolled Housing Transition/Sustaining provider. This will then be sent to DHS, who will review the paperwork and either approve or deny. Once a decision is made, Medica will receive an approval notice in the form of a letter and will enter it into Medica's system. If the member changes providers, or their plan changes, DHS will send Medica the updated information.

How long does the authorization process take and how will I know that services have been approved?
Refer to DHS regarding their turnaround time for reviews and notifications. Once Medica receives the DHS information, an authorization will be entered within 10 days and an authorization letter will be sent to the HSS provider. You will get two approval letters- one from DHS when the services are approved and another from Medica once the referral has been entered into our system.

How can I identify the Care Coordinator?
All Medica Dual Solution (MSHO), Minnesota Senior Care (MSC+), AccessAbility (SNBC), and AccessAbility Enhanced members are assigned to a Care Coordinator. If you need to speak with the member's assigned care coordinator and do not have this information, call the Provider Service Center at 1 (800) 458-5512 and they can look it up for you. Care coordinator delegate contact information can also be found on the ***County, Care System, and Agency Contact Information page*** *on the Medica website.*

How do I bill for these services?
You will bill services on a CMS-1500 (HCFA) form. For a Sample CMS-1500 Claim Form and billing requirements, see ***Medica.com/Administrative Resources/Claim Tools*** *under the Claim Forms section. Claims can be billed paper or electronically. For additional information on how to submit claims electronically, see below question about registering with a clearinghouse.*

Claim Submission for *Medica Choice Care PMAP:*

Electronic Payer ID: MEDM1
Medica Government Programs
PO Box 21342
Eagan, MN 55121-0342

Claim Submission for *Medica DUAL Solution (MSHO), Minnesota Senior Care Plus (MSC+), Medica AccessAbility Solution (SNBC), Medica AccessAbility Solution Enhanced (SNBC SNP)*:

Electronic Payer ID: 94265
Medica
PO Box 30990
Salt Lake City, UT 54130-0990

What is a clearinghouse, and how do I get set up with them?
A clearinghouse allows you to submit secure claims electronically to an insurance payer. You will upload a file that is sent to the medical billing clearinghouse account. The clearinghouse then scrubs the claim to check for errors. Once it passes inspection, the clearinghouse securely transmits the electronic claim to the specified payer with which it has already established a secure connection that meets the strict standards laid down by HIPAA. Minnesota E-Connect is a free clearinghouse established to meet AUC guidelines for MN electronic billing requirements. For additional information on electronic claims submission, or to register with MN E-Connect, go to ***Medica.com/Administrative Resources/Claim Tools*** *under the "Electronic Claim Submission" section.*

I'm enrolled with DHS. Are there any additional steps I need to take before I can submit my first claim to Medica?
Once you have gone through the DHS provider enrollment process and Medica receives confirmation of this from DHS, Medica will need to add your information to their claims systems in order to ensure prompt and accurate payments. To complete this setup, you will need to send an Out-of-Network Provider Setup Form along with a W-9 to Medica. This form can be found at ***Medica.com/Administrative***

Resources/Claim Tools *under the Electronic Claims Submission section (Out-of-Network Provider Setup Form). When Medica receives this information, we can create a unique provider ID in our system that ties to your organization and billing information. If you submit claims before this step is complete, your claim will reject. For additional questions and assistance with setup, contact the Provider Service Center (PSC) at 1-800-458-5512, and let them know that you are interested in more information or have questions about the Out-of-Network Provider set up process. The* ***fastest and easiest way to get set up is by contacting the PSC directly****. Then you can fax the necessary forms directly to the rep you speak with for handling, instead of faxing to the general PSC fax number listed on the form.*

Note: If you are already set up as a contracted provider with Medica and will be billing Housing Stabilization services in addition to services you already bill, requirements will vary based on current setup. Please contact the Provider Service Center to determine if you will need to follow the above process, or if you can bill under your current setup.

What should I do if I need to make a demographic change?
Any demographic changes need to be made first with DHS. Once the DHS file is updated, you will contact the Provider Service Center (PSC) and follow the set up process outlined in the above section. On the Out-of-Network Provider Setup Form, you will check the box for "system update", instead of "Initial setup".

Note: If the demographic information you are billing does not match what Medica has on file, claims will not be processed/paid. It is very important to keep all demographic information up to date.

Watch a short instructional video on how to complete the Out-of-Network Provider Setup Form for initial setup and demographic changes by clicking on ***this link****.*

What codes do I use for billing? Are there any unique coding considerations we need to be aware of, such as visit limits or required modifiers?
The DHS-assigned HCPCS codes for Housing Consultant, Transition, and Sustaining services are:

- *Housing Consultant: T2024, U8 modifier required*
- *Transition: H2015, U8 modifier required*
- *Sustaining: H2015, U8/TS modifier required*
- *Moving Expenses: T2038, U8 modifier required*

Visit limits and extensions are determined based on the Prior Authorization obtained from DHS. Also, DHS has provided information about what constitutes a conflict of interest, as well as services that cannot be billed at the same time as HSS. See the DHS site for more information: ***https://mn.gov/dhs/partners-and-providers/policies-procedures/housing-and-homelessness/housing-stabilization-services/housing-stabilization-services.jsp***

Moving Expense details:
Effective 4/1/2024, this benefit provides a $3000 non-reoccurring moving expense allowance for eligible members transitioning out of a Medicaid funded institution or leaving a provider-operated living arrangement and moving into their own home.

Provider Billing Requirements for Moving Expenses:

- Receipts are required to be submitted as an attachment
    - Must have the name of the business, the date and time of purchase and be itemized
    - Must only be for the individual recipient
- Each Moving Expense receipt must be billed on a separate line
- Multiple Moving Expenses purchased on the same date must be bundles with total $ and one unit.
    - Example: combine microwave and bed sheets purchased on the same date
- Providers are reimbursed based on the total amount of submitted claims/receipts
    - Cumulative max of $3,000 per member
- Bill separately from other Housing Stabilization/Transition service components

What are Electronic Payments and Statements (EPS), and how can I sign up?

Signing up for Electronic Payments and Statements is a way to set up and receive all payments electronically via direct deposit, along with access to electronic versions of Provider Remittance Advices (PRAs) and Explanations of Benefits (EOBs) via a secure log in with our 3rd party EPS vendors, as an alternative to paper checks and PRAs/EOBs received via standard mail.

Signing up for EPS for *Medica Choice Care PMAP:*

The vendor used for our Medica Choice Care (PMAP) product is InstaMed. In order to sign up for EPS with InstaMed, you will need to email ***MedicaHSS@medica.com*** and request a copy of the *InstaMed Payer Payment Setup Form*. Then return the form, along with a bank letter/canceled check and copy of a recent EOB, to InstaMed for review. Once approved by the underwriting and compliance departments, EPS transactions and direct deposit will become available.

Please note: On the *Payer Payment Setup Form* where it asks for a national provider identifier (NPI) number, if you only have an UMPI number, put that number in the NPI space instead.

Signing up for EPS for *Medica DUAL Solution (MSHO), Minnesota Senior Care Plus (MSC+), Medica AccessAbility Solution (SNBC), Medica AccessAbility Solution Enhanced (SNBC SNP)*:

The vendor used for these products is Optum Health Financial Services. You can get set up for electronic funds transfer (EFT) by doing one of the following:

- Call 1 (866) 842-3278, option 5
- Sign up for a One Healthcare ID at: ***https://identity.onehealthcareid.com/app/index.html#/login*** (this is a United Healthcare website).

How can I submit claims with an UMPI number vs. an NPI number?

Electronic Submission:

- In loop 2010AA, the Tax ID needs to be sent in a REF segment. If the provider has an NPI, this is also submitted in the 2010AA loop.
- In loop 2010BB, there needs to be a REF*G2 segment containing the UMPI. This tells the receiver that it is an atypical provider number.

- If a provider submits an atypical provider number/UMPI in the 2010AA loop, it can cause an error or rejection at the clearinghouse because the NPI is a numerical 11-digit ID. The UMPI is 11 digits, but starts with a letter.

Paper Submission:

- On a hardcopy CMS-1500 form, these loops and segments correlate to box 33:
- Box A (equal to 2010AA) enter the NPI OR
- Box B (equal to 2010BB) enter the atypical/UMPI number

How can I submit attachments along with my claim, such as invoices, itemized bills, etc.?

To submit supporting documentation with your claim, follow the standard AUC process.

Helpful links:

AUC Uniform Cover Sheet and Instructions for Health Care Claim Attachments

Fax and Appeals Submission Contact Information (state.mn.us):

- All Numeric Group #'s (MSHO, MSC+, SNBC, SNBC SNP)- use Medica Health Plan Fax #
- Alpha-Numeric Group #'s (PMAP)- use the Medica2 Health Plan Fax #

Who can I contact if I have additional questions?

Please call Medica's Provider Service Center at 1 (800) 458-5512.