Set-Up and Billing for Elderly Waiver (EW) and Housing Stabilization (HSS) Providers

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MISSION

To be the trusted health plan of choice for customers, members, partners and our employees.

VISION

To be trusted in the community for our unwavering commitment to high-quality, affordable health care.

VALUES

Customer-Focused • Excellence • Stewardship • Diversity • Integrity

Agenda:

Overview: Housing Stabilization Services (HSS)
Overview: Elderly Waiver Services (EW)
Non-Par Provider Setup for HSS and EW services
Role of the Care Coordinator
EW and HSS Authorizations
Claim Submission Process
Claim Appeals and Adjustments
Resources and Trainings
Q&A Session

Overview: Housing Stabilization Services (HSS)

What are Housing Stabilization Services (HSS)?

- Housing Stabilization Services are a MN Medical Assistance benefit that assist people with disabilities (including mental illness and substance use disorder) and seniors to find and keep housing

- The goals (outlined by DHS) of HSS are to:
  - Support an individual's transition to housing (Housing Transition Services)
  - Increase long-term stability in housing (Housing Sustaining Services)
  - Avoid future periods of homelessness or institutionalization (Housing Sustaining Services)

**If you are not currently an HSS provider, but interested, find more information here.

Medica Plans with HSS Benefits

- Available for all Medicaid members that meet eligibility criteria:
  - Medica Dual Solution (MSHO): Group # 07XXX
  - Minnesota Senior Care Plus (MSC+): Group # 59XXX
  - Medica AccessAbility Solution (SNBC): Group # 05XXX
  - Medica AccessAbility Solution Enhanced (SNBC SNP): Group # 08XXX
  - Medica Choice Care PMAP: Group # A00500

Overview: Elderly Waiver (EW) Services

What are Elderly Waiver (EW) Services?

- Elderly Waiver (EW) services are part of a program that funds home and community-based services for people age 65 and older who require the level of care provided in a nursing home and choose to live in the community

- EW promotes community living and independence with services and support that address each persons individual needs and choices that go beyond what is available through Medical Assistance

Elderly Waiver Providers

- The following provider types can bill Elderly Waiver Codes:
  - Skilled Nursing Facility (SNF)
  - PCA Agency
  - Home Health Care Agency
  - Elderly Waiver (non-contracted)
  - Durable Medical Equipment providers

- Providers must meet home and community based services (HCBS) billing and service documentation requirements for these services
  - See DHS provider manual for more information

Medica Plans with Elderly Waiver Benefits

- MSC+ (Minnesota Senior Care Plus)
  - Members are 65+, Medicaid plan only. Some plans have Medicare as Primary, some do not
  - Group # 59XXX
- MSHO (Dual Solution)
  - Members are 65+, replaces both Medicare and Medicaid
  - Group # 07XXX

Non-Par Provider Setup for HSS and EW Services

Provider Requirements

- In order to be set up as a Medica provider, you need to be registered with the Minnesota Department of Human Services (DHS)

- Just because a provider is set up to bill EW or HSS services does not mean they are contracted with Medica

- When looking for an Elderly Waiver provider, the Medica Care Coordinators use the Waiver Services search on the DHS resource: MnHelp.info

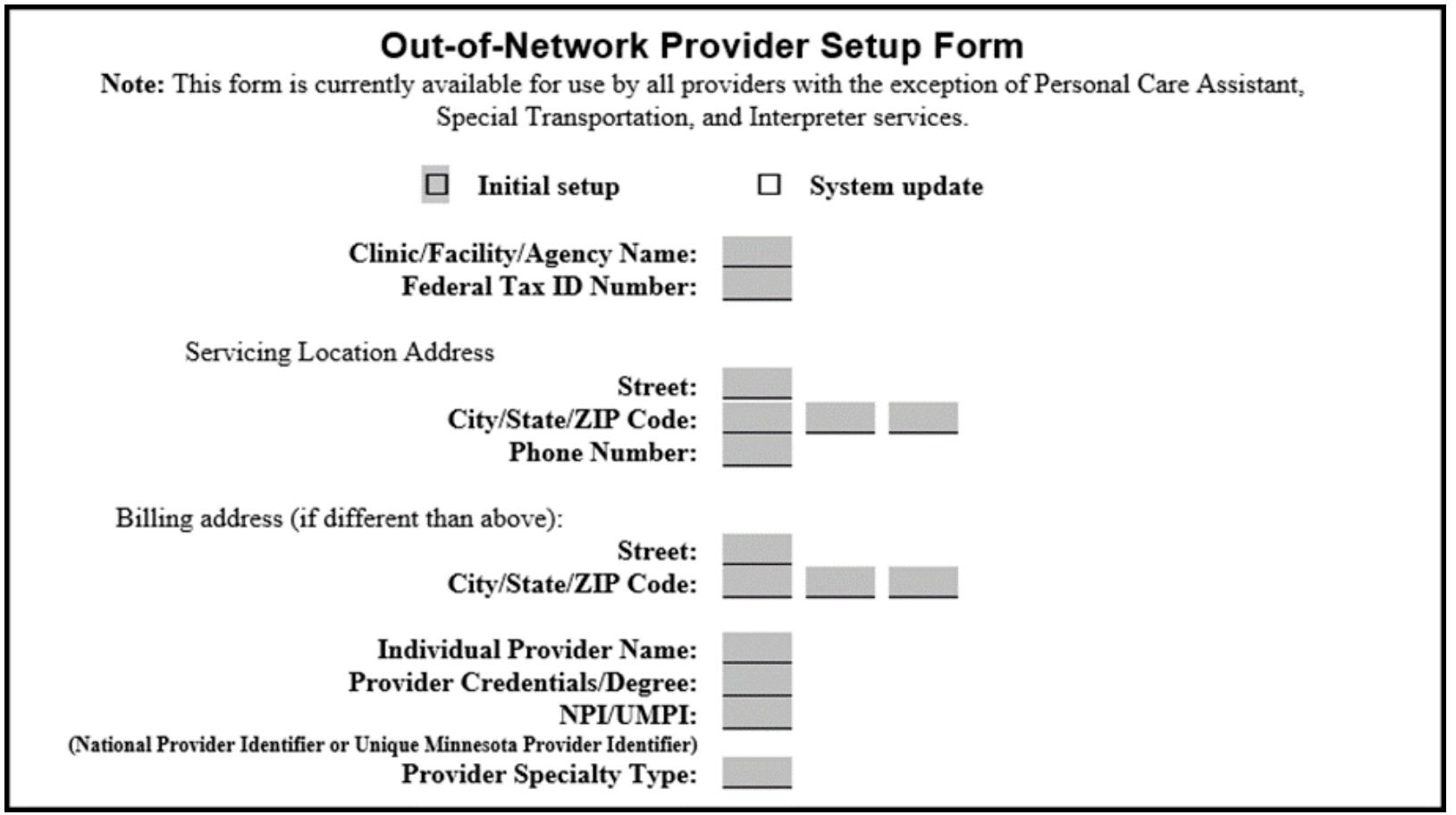
Setup at Medica

- Providers should call the Provider Service Center (PSC) at 1-800-458-5512 to be set up as a non-contracted provider
  - Do not ask to be “contracted” with Medica, it is not necessary for EW or HSS Services
  - Take note of the person you work with in the PSC and ask for a reference number, in case there are any issues with the set-up

- Once initial contact is made with the PSC, the provider will need to fax a copy of their W9 and an Out-of-Network Provider Setup Form to the PSC representative
  - Medica.com-> For Providers-> Administrative Resources-> Claim Tools: Electronic Claim Submission/Out-of-Network Provider Setup Form section

- The PSC rep will have the provider information added to the Medica system. Once the provider is set up (typically 10-14 business days), they can begin submitting claims

Out-of-Network Provider Setup Form:



Out-of-Network Provider Setup Form

Note: This form is currently available for use by all providers with the exception of Personal Care Assistant, Special Transportation, and Interpreter services.

☐ **Initial setup** ☐ **System update**

Clinic/Facility/Agency Name: _____
Federal Tax ID Number: _____

Servicing Location Address

Street: _____
City/State/ZIP Code: _____ _____ _____
Phone Number: _____

Billing address (if different than above):

Street: _____
City/State/ZIP Code: _____ _____ _____

Individual Provider Name: _____
Provider Credentials/Degree: _____
NPI/UMPI: _____
(National Provider Identifier or Unique Minnesota Provider Identifier)
Provider Specialty Type: _____

Out-of-Network Setup Micro-training

Medica.com-> For Providers -> View Trainings -> Micro-Tranings -> Out-of-Network Provider Setup Form Training Video

Quick video that walks you through how to properly fill out and submit the Out-of-Network form to get setup for billing to Medica!

Additional Set-up Tips:

- If you are contracted for behavioral health services with Medica, you will still need to complete the OON setup process for EW or HSS services
- A separate form will need to be completed for each location/Tax ID
  - Medica sets up an internal “legacy number” that is tied to each provider type and location
  - This number is also tied to all affiliated authorizations and our claim processing system
  - If all of the information does not match, claims will not process and pay
- Information approved through DHS provider enrollment must match how they are set up on the Medica OON setup form
- DHS does not alert us of any business changes, they need to be submitted directly to Medica (this applies to both demographic changes and authorizations)

Role of the Care Coordinator

Overview

Care Coordinators are responsible for:

- Conducting an annual assessment and creating a person centered care plan
- Assisting with paperwork, housing, local food banks, emergency funding, and other activities
- Coordinating medical, mental health and dental appointments
- Organizing specialists needed for various medical conditions
- Coordinating transportation to and from appointments with Medica Provide-A-Ride and other sources
- Disease prevention management and education
- Determining EW/HSS services needed and authorizing accordingly
- Working collaboratively with providers or county waiver workers (CAC, CADI, BI, DD)

Identifying a Care Coordinator

- All MSHO, MSC+ and SNBC members are assigned a Care Coordinator who is familiar with the area where the member lives
- The Care Coordinator could be directly with Medica, one of our County Partners, Care Systems, or Agencies
- To identify a Care Coordinator, contact the Provider Service Center at **1-800-458-5512**
- Additional Contact Information: County Partners, Care Systems and Agencies- Phone and Fax Numbers
- Medica Choice Care PMAP and Medica MinnesotaCare members do NOT have Care Coordinators

Care Coordinator or Provider Service Center?

- Care Coordinator:
  - Discuss member specific issues, Authorization Questions/Changes for EW (example: rendering provider name change)
- Provider Service Center:
  - Billing/Claim Questions
  - Out-of-Network Setup/Demographic Change Requests

HSS and EW Authorizations

Elderly Waiver Authorization Requirements

- Care Coordinators are responsible for authorizing Elderly Waiver services prior to administration

- Some services require written prior authorization for claims to pay, while others only require verbal authorization from the Care Coordinator

- Medica's Utilization Management team does not answer questions related to EW authorizations, always address directly with the Care Coordinator

Housing Stabilization Service Authorization Requirements

- The HSS provider will work with the Care Coordinator to develop a plan and submit to Department of Human Services (DHS)

- Approval/Denial will be made by DHS and sent to Medica. You will get two approval letters- one from DHS upon approval, another from Medica when the referral has been entered into our system (within 10 days of approval)

- If a member changes providers, or their plan changes, DHS will send Medica the updated information so it is listed under the current policy

Additional Housing Stabilization Tips

- HSS provider listed on the DHS letter must match the provider billing for services or claims will not be processed
- Notification of HSS approval is also sent to the Care Coordinator for awareness
- If something doesn’t look right with an authorization, reach out accordingly
- All provider setup, benefit and claim questions are to be discussed with the Provider Service Center (PSC), not the Care Coordinator

Claim Submission Process

Overview:

- A claim is submitted either on paper or electronically to Medica
  - Electronic claims are accepted through clearinghouses, who then forward to Medica
  - MN providers are required to submit all claims electronically

- There are two different types of claims:
  - CMS-1500: Physician claim forms
  - UB-04: Facility claim forms

- All claims must follow MN Administrative Uniformity Committee (AUC) Guidelines

- Once a claim is submitted to Medica, it is either accepted or rejected

Medica Claims Address and Payer ID

P.O. Box 30990

Salt Lake City, UT 84130-0990

Electronic Payer ID: 94265

** All Numeric Group #’s (MSHO, MSC+, SNBC, SNBC SNP)

P.O.Box 21342

Eagan, MN 55121-0342

Electronic Payer ID: MEDM1

**Alpha-Numeric Group #’s (PMAP)

Submitting Claims through a Clearinghouse

- A Clearinghouse allows you to submit secure claims electronically. They scrub the claim for errors, then securely transmit the electronic claim to the insurance payer
  - Billing can be done in batches, rather than one member at a time
  - If a claim is rejected, you will receive an Advanced Claim Edit denial code

- MN E-Connect is an example of a free clearinghouse established to meet AUC guidelines for MN electronic billing requirements
  - To register with MN E-Connect, contact HealthEC at 877-444-7194
  - Technical assistance is also available via phone or email at support@healthec.com

Claim Statuses

- Rejected: Medica does not have the claim on file
- Accepted/Pending: Claim has been received by Medica
- Paid: Claim has been fully processed and paid
- Denied: Claim has been fully processed and denied

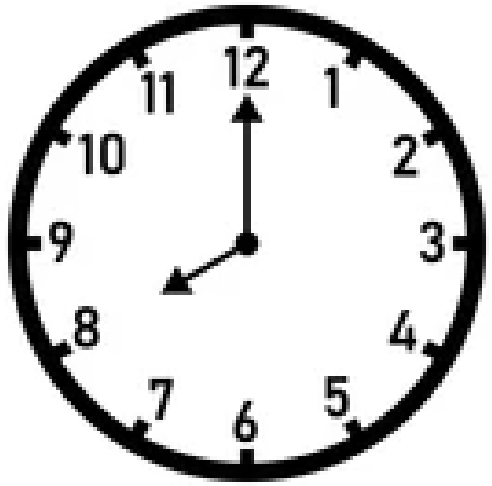
Rejected Claim Process

- Rejected claims are typically not on file at Medica
- When a claim is rejected for missing/invalid information, provider should work with the Provider Service Center (PSC)
  - PSC will confirm if an image of the claim is on file
  - Demographic and claim information will be reviewed for accuracy
- If you have not completed the non-par setup process with Medica, your claim will reject
- Refer to the Advanced Claim Edits (A.C.E.) document on Medica.com for a list of rejection codes and descriptions

Accepted Claim Process

- Once a claim is accepted, it goes through claim edits that are required by CMS and DHS based on correct coding guidelines
- Medica uses Coverage Policies, Reimbursement Policies and Utilization Management Policies to determine if and how a claim should pay
- For authorized services, claims will pay per the instruction on the Prior Authorization

Timely Filing Guidelines



- Original claims must be received by Medica within the following timeframes:
  - 180 days: Contracted Providers
  - 365 days: Non-Contracted Providers
- Adjustments/Appeals must be received within the following timeframes:
  - 365 days from the date claim was originally processed
  - 60 days from denial date (if denied for lack of Prior Authorization)

Additional Timely Filing Guidelines

- Adjustments due to: (1) Coordination of Benefits recovery; (2) payments subject to subrogation recovery; (3) duplicate claims payments; and (4) retroactive terminations due to a retroactive determination of a member's eligibility for a government program or subsidy, are not considered corrective adjustments and may be made at any time

- Click here for Medica's complete Timely Filing and Late Claims Policy, found on medica.com

Claim Appeals and Adjustments

Claim Adjustments

- An adjustment is requested when you are changing information that was initially submitted on a claim
- This can be submitted on the Claim Adjustment or Appeal Request Form, or as a Corrected Claim electronically
- Generally, adjustments are submitted to correct coding errors that were originally submitted

Claim Appeals

- An appeal is requested when you are not changing information that was initially submitted on a claim, but requesting a different outcome
- Make sure you understand the details of a denial before submitting an appeal
- Submit the appeal using the Claim Adjustment or Appeal Request Form found here under the Adjustment and Resubmission Processes section
  - Include explanation and supporting documentation
  - Indicate where to find relevant details in the documentation
- If an appeal is denied and you have new information, submit a second level (final) appeal

Resources and Training

Setup for Electronic Payments and Statements (EPS)

Providers can sign up directly for EPS with the following vendors:

- Alpha-Numeric Group #’s: (PMAP)
  - Registration page at InstaMed: https://register.instamed.com/eraeft
  - Questions on how to register?
    - Call: 1-866-945-7990
    - Email: connect@instamed.com
- All Numeric Group #’s: (MSHO, MSC+, SNBC, SNBC SNP)
  - Registration page at Optum: https://provider.linkhealth.com/#/

Signing up for EPS gives you the option to review all Explanation of Benefits (EOB’s) and Provider Remittance Advice (PRA’s) online and receive payments electronically via Direct Deposit

Provider Training Opportunities

Medica.com-> For Providers -> View Trainings

- Classes: delivered monthly via live webinar
- E-Learnings: interactive trainings available on-demand
- Micro-Trainings: quick “how to” videos on various processes

Email ProviderCollege@Medica.com with any feedback/requests!

Need Further Assistance?

Contact the Medica Provider Service Center!

1-800-458-5512

Call Center hours (CST):

- Monday 7:00 a.m. to 5:00 p.m. Central Standard Time (Closed 8:00 a.m. to 9:00 a.m. for department meetings)
- Tuesday-Friday 7:00 a.m. to 5:00 p.m. Central Standard Time

Additional Resources:

Medica FAQ for Housing Stabilization Services

DHS Website Resource (for HSS)

Thank You!