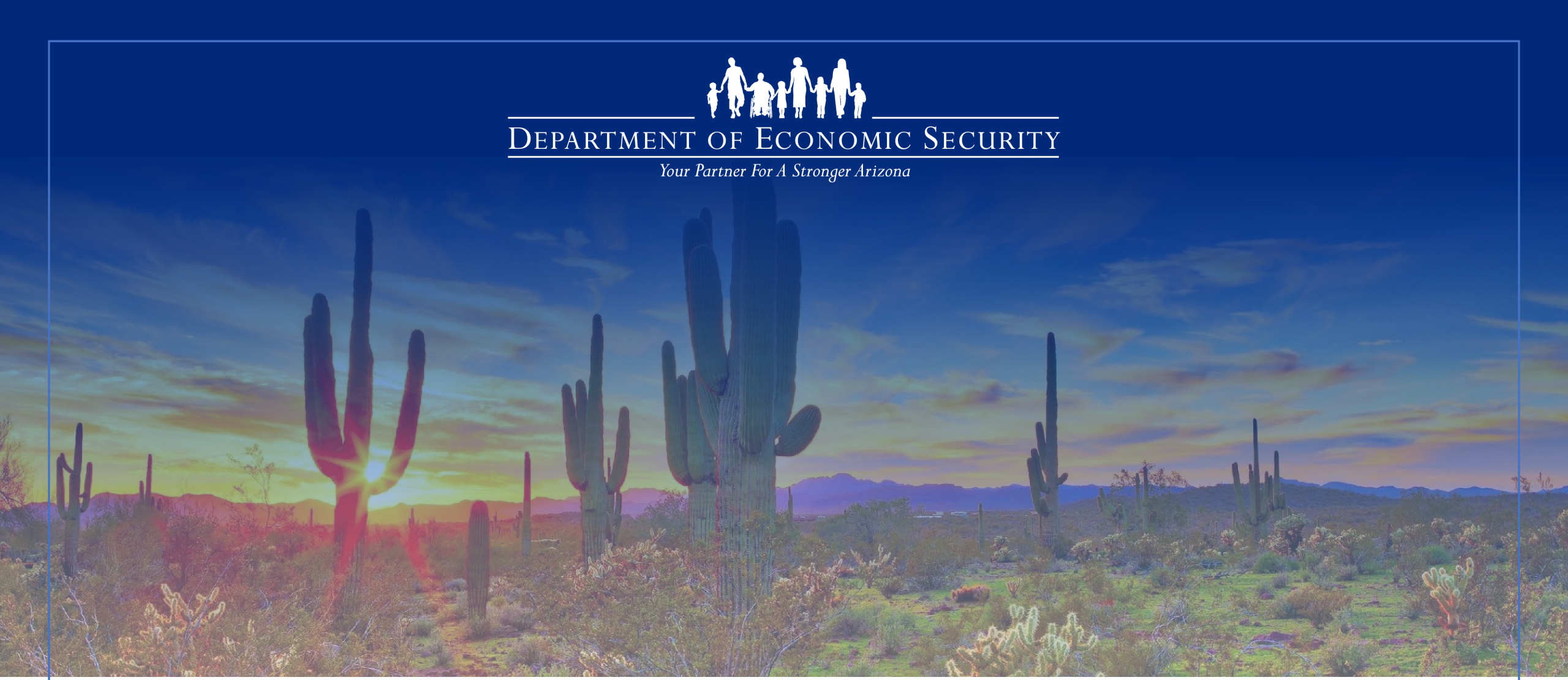
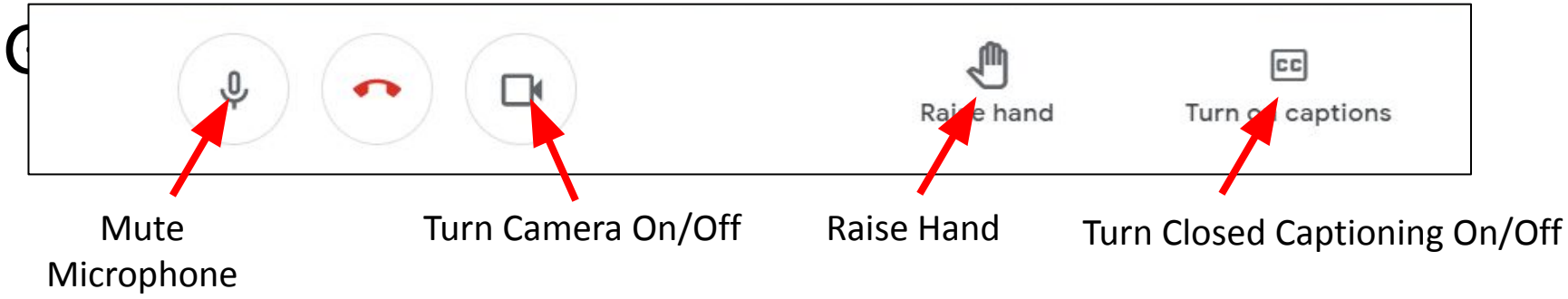


Division of Developmental Disabilities
Claims Billing Technical Guidance Training

Updated 7/13/2021

Welcome!

- Please mute your microphones
- If you have a question, please use the “Raise Hand” feature OR type your question in the Chat box



Agenda

- Introductions
- Welcoming Remarks
- Claims Processing Flow
- Technical Guidance
- Questions and Answers

Introductions

- AZ Division of Developmental Disabilities
  - Patrick Hays
  - Katherine Goldcamp
  - Vanessa Holt
  - Stephanie Erickson
  - Desirae Alvarado

Welcoming Remarks

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Why is a new system being implemented?

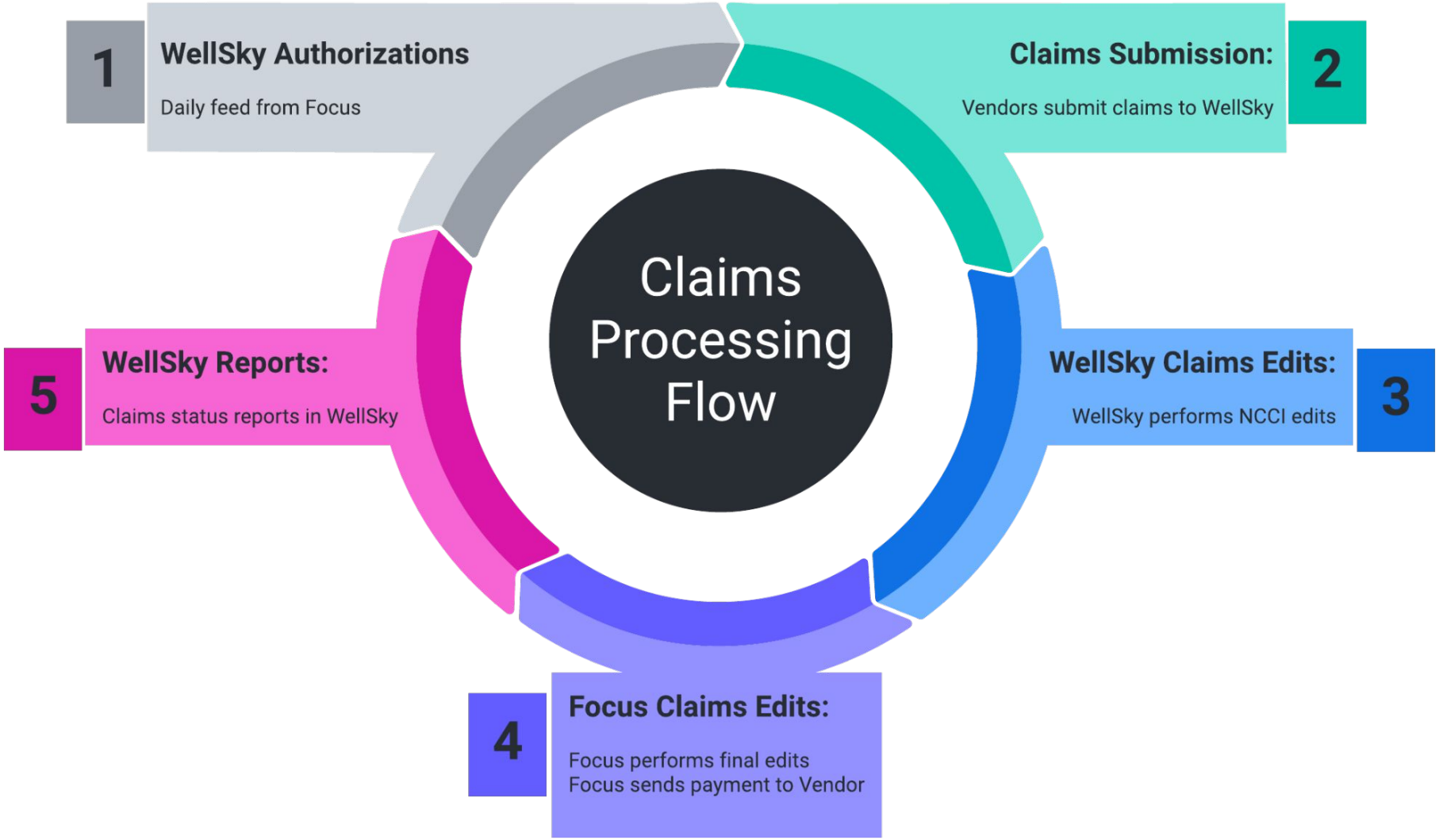
As part of the Division's Current 2 Future Initiative, a vendor was selected to help DDD update its claim system in order to be compliant with state and federal regulations and to resolve the AHCCCS HIPAA TCS Compliance Claims Processing System Notice to Cure. This determination was based on DDD not utilizing the Healthcare Common Procedure Coding System (HCPCS) and standard Centers for Medicare & Medicaid Services (CMS) claims forms when reimbursing Qualified Vendors for submitted claims.

This will include the use of standardized Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets (TCS) in lieu of DDD proprietary codes currently being used by vendors when submitting claims.

When the Wellsky system is implemented on July 1, 2022, vendors must submit claims on official, nationally-recognized forms. The current DDD billing template will be replaced by these forms. Vendors will have three options for submitting claims:

1. Submit an electronic 837 form
2. Manually enter claims directly in Wellsky for each authorization
3. Submit a CMS 1500 form in paper form

Wellsky System Claims Process



What is changing?

- Vendors will need to use several new codes for claims billing
  - HCPCS/CPT codes instead of three-alpha service codes
  - WellSky Authorization ID
  - Vendor Submit ID
  - ICD-10 Diagnosis Codes and Pointer
  - New Modifiers
  - New Forms - will not be supplied by DDD
- Several current items remain and are still needed

What is changing?

- Vendors will need to use WellSky for claims submission

  - Vendors will be assigned a username/password for WellSky
  - Vendors will need to identify two people to be WellSky users
    - Login in to the Focus and select the Admin Tools application.
    - Choose “Users” at the top of the page.
    - Click the “Assign” button in the column labeled “Access to WSHS” for up to two individuals who will be able to access the claims system.
    - If you are using a third party biller, please identify them in Focus

Training Classes

- Vendors will need to attend two different training classes

- WellSky User Interface Training
  - Login
  - View/Download Reports
  - Upload 837P files

- Claims Technical Guidance Training
  - Claims Coding
  - Policies

Claim Billing Details

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Claim Form Types

Vendors will have three options for submitting claims:

1. Submit an electronic 837 form (preferred)
2. Single Claim Entry in the WellSky portal
3. Submit a CMS 1500 form in paper form

CMS Resources:
https://www.cms.gov/files/document/837p-cms-1500pdf

Resources and companion guides can be found on the Division's website:
https://des.az.gov/services/disabilities/developmental-disabilities/current-2-future-initiative/hipaa-tcs

Claim Required Elements

- Provider, Member (Name, ID, Address)
- ICD-10 Diagnosis Code
- WellSky Auth ID#
- ICD-10 Pointer
- Date of Service (DOS)
- HCPCS Code
- Modifier/s
- Place of Service (POS)
- Total Charges per Line
- Units
- Rendering Provider NPI or AHCCCS ID#.

*Highlighted items are new

No longer included: unit rate, provider site code

ICD-10 Codes

ICD-10 is the International Classification of Diseases - 10th Revision.
Used to classify health issues on claims.
Required on **every claim** submission.
World Health Organization (WHO) is the governing authority.

All claims must include a diagnosis code relevant to the service provided.

DDD Eligibility diagnoses are included in **FOCUS PBS Vendor Detail Report** listing your current members.

Wellsky Authorization ID

- Claims will be required to be submitted with the WellSky Authorization ID, not the FOCUS Authorization ID.

- Vendors can download all authorizations into an Excel or CSV file from WellSky system that will have WellSky Authorization ID

Place of Service 12 vs 14 Change

12 - **Home**. Location, other than a hospital or other facility, where the patient receives care in a private residence.

14 - **Group Home**. A residence, with shared living areas, where members receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).

Rate Book

Conversion to the unit as outlined per the associated HCPCS.

- CMS rounding rule of 51% -> for per 15 minute requires at least 8 minutes for a billable unit, for per hour requires at least 31 minutes for a billable unit

Example: an hour and 40 minutes of direct care time

Current

Service Code	Unit: per Hour	Amount per unit	Total Charges
ATC	1.75	$ 20.52	$ 35.91
RSP	1.75	$ 20.10	$ 35.18
HAH	1.75	$ 24.49	$ 42.86

Service Code	Unit: per Hour	Amount per unit	Total Charges
S9123	1.75	$ 59.84	$ 104.72

WellSky

HCPCS	Unit: per 15 minutes	Amount per unit	Total Charges
S5125	7	$ 5.13	$ 35.91
S5150	7	$ 5.03	$ 35.21
T2017	7	$ 6.13	$ 42.91

HCPCS	Unit: per Hour	Amount per unit	Total Charges
S9123	2	$ 59.84	$ 119.68

➢ per unit we rounded all services up to ensure a least level funding by service

Billing Coding Guides

Each DDD service code is listed on a single page

Critical information: HCPCS Code, Unit, Medicare Coverage, Third Party Liability, EPSDT, Procedure Daily Maximum, ROPA, POS, Modifiers, NCCI Edits link, COS, Modifier Hierarchy

https://docs.google.com/document/d/1nxaEd7HCQDyQFwRE1nEaJCxH5YGld2_aHXnTWkzossk

Date of Service - Span

Date span billing is permitted for ‘per diem’ services. All the claim data must be consistent such as daily rate. Date span cannot cross different months.

Acceptable Examples:

- Group home - 2/1/2022 to 2/28/2002 - 28 Units - Daily rate stayed the same for all 28 days
- Group home - 3/1/2022 to 3/10/2002 - 10 Units - Daily rate stayed the same for all 10 days

Bundling Claims for Single Service

- Hourly and Per 15 minute services are allowed to be bundled where the total units for a single day can be submitted in one claim as long as all the claim information data is the same. If the rate, or ROPA data, the claims should not be bundled and should be submitted separately.

Third Party Liability Process

- TPL and Waiver process remain the same. Waivers will still be required for FOCUS to issue payments.

- Pended claims will not be available for Provider changes or automated resubmissions.

- For claims with TPL payments, enter the full amount paid by TPL, even when greater than the DDD Rate.

Rate vs. Informational Modifiers

Modifiers are also categorized by type

- Rate modifiers (payment-impacting modifiers; reimbursement modifiers; payment modifiers)

- Informational modifiers

Rate vs. Informational Modifiers

- A rate modifier causes a pricing change for the code reported.
- CMS requires pricing modifiers to be in the first modifier position/s, before any informational modifiers.
- CMS 1500 claim form, the appropriate field is 24D.
- DDD distinguishes rate modifiers from informational modifiers for DDD claims.
- See the DDD Coding Guide - Rate Book Companion.

Time of Day Modifiers

- Time of Day modifiers are currently informational only and not required for DDD.

- Do not use Time of Day modifiers to circumvent Claim Correction process. This is not proper claim billing and could have negative impact to the EVV validation process.

- WellSky will require corrected claims.

Nursing Code Billing

Skilled-Nursing services should bill with the appropriate HCPCS code based on the skill level of the nurse providing services.

The authorizations will be for the LPN level. Agencies should use the corresponding HCPCS code if an RN provides service.

One change:

Nursing Respite, S5150
Modifier TD (RN) or TE (LPN)
15 minute units

Claims Replacement Process - Focus Claims Paid Pre-WellSky

For all dates of service billed exclusively via FOCUS (DOS that do not exist in WellSky), those claims require correction via email with DDD-Claims@azdes.gov

Prepare the DDD Uniform Billing Document following the Claim Replacement Process for LTC Claims. Once the document is created by the Provider, email it to DDD-Claims@azdes.gov

The Claims Unit will handle the documents on behalf of the Provider. These will be manually entered into FOCUS.

Claims Correction Process - Claims Paid in WellSky

- 837P and CMS 1500 will use ‘code’ 7 for corrections
- Provider will need to identify the previous claim submission ICN (Internal Control Number) from WellSky
- This links the corrected claim to the initial claim, preserving timely filing

- 837P and CMS 1500 will use ‘code’ 8 for reversals or voids
- Provider will need to identify the previous claim submission ICN (Internal Control Number) from WellSky
- This identifies the claim to be reversed or voided

Example: S5125 (Attendant Care)

- HCPCS code = S5125
- Unit: 15 minutes
- Medicare Coverage: No
- Third Party Liability: No
- EPSDT (Early and Periodic Screening, Diagnostic, Testing): No

Example: S5125 (Attendant Care)

- Procedure Daily Maximum: 96 units
  - 15 minute unit x 96 units = 1,440 minutes
  - 1,440 minutes ÷ 60 min/hour = 24 hours per DOS

- ROPA: No

Example: S5125 (Attendant Care) MODIFIERS

- Modifiers: required when appropriate
  - TN – Flagstaff; Rural
  - CG – Incentive Rate; Policy criteria applied
  - UN – Two members served
  - UP – Three members served
  - U3, U4, U5 – Family/Spouse modifiers
  - U7 - Agency with Choice

Modifier Hierarchy - S5125 (Attendant Care)

- Flagstaff [TN] as the first modifier, if needed;
- Incentive rate [CG] as the next modifier, if needed;
- Members served [UN, UP] as the next modifier, if needed;
- Rendering provider [U3, U4, U5, U7] as the next modifier, if needed;
- Time of day [UF, UG, UH, UJ] as the next modifier, if needed

Example Claim - S5125 (Attendant Care)

4 hours of Attendant Care rendered Friday, July 1

Member lives in Flagstaff; ICD-10 is F79

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. F79 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Wellsky AUTH ID#

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 07	01	22	07	01	22	12		S5125	TN	A	96.48	16		NPI	123456

FORMATION

Website

C2F - HIPAA TCS Compliance Claims Processing System dedicated website
https://des.az.gov/services/disabilities/developmental-disabilities/current-2-future-initiative/hipaa-tcsg%20System

Resource Documents:

- WellSky General Topics and Frequently Asked Questions
- Billing Guide: CMS 1500 Form
- WellSky 837P Companion Guide
- DDD Medical Coding with Modifiers Reference Sheet
- DDD Provider Coding Guide: Rate Book Companion
- Division Provider Policy Manual Chapter 57 Third Party Liability

Questions and Feedback

Questions, comments, suggestions?