Health Plan of San Joaquin

CLAIMS CORNER

A monthly newsletter brought to you by Health Plan of San Joaquin May 2018

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Providers are encouraged to routinely check the *Medi-Cal Update* provider bulletins and complete the MCSS Subscriber Form to receive email notifications for newly published *Medi-Cal Update* bulletins, *Newsflash* articles and/or System Status Alerts.

Submitting a Corrected Claim—Reminder

- Correcting **electronic** CMS-1500 claims— enter claim frequency type (billing) code 7, for replacement/correction in the 2300 loop in the CLM*05 03
- Correcting **paper** CMS-1500 claims—fill out box 22 (resubmission code) to include code 7 to let us know this is a correct or replacement claim.

NOTE: Corrected claims should be sent with **ALL line items** filled out for that claim and they should never be filed with just the line items that need to be corrected.

Changes coming in 2019

Audiology/EPSDT Audiology & Speech Therapy (Therapies—Bulletin 511**)**

The Audiology/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Audiology and Speech Therapy code conversion replaces non-HIPAA-compliant HCPCS Level II codes (local codes), with HIPAA-compliant CPT codes. HIPAA mandated these changes to billing requirements for Audiology/EPSDT Audiology and Speech Therapy providers.

- *Crosswalks and FAQs will be available soon and additional information for this project will publish as details are determined on the MCL website.*

Hospice Routine Home Care Updates

** see copy of attached bulletin*

*"Reminder -**Effective February 1, 2017**, Medical Necessity Reviews from providers who fail to obtain prior authorization **will no longer be reviewed for consideration, unless** the dispute is one where it was thought that the member had other primary health coverage at the time services were rendered. **ALL** authorizations must be submitted before services have been rendered"*

- Provider Alert 12.19.16

Medi-Cal Update

Hospice Care Program | April 2018 | Bulletin 523

1. Hospice Routine Home Care Updates

Federal Rule 42 CFR Part 418, CMS–1629–F, RIN 0938–AS39 Medicare Program; *FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements* establishes an updated reimbursement rate of differential payments for routine home care based on the recipient's length of stay, and implements a service intensity add-on (SIA) payment for services provided by a registered nurse or social worker in the last seven days of a recipient's life for at least 15 minutes and up to four hours total per day.

Effective retroactively for dates of service on or after January 1, 2016, with a system implementation date of May 1, 2018, hospice providers are required to bill new revenue codes for routine home care services and SIA.

The existing local Medi-Cal revenue code 0651 (hospice service, routine home care) will be end-dated and replaced by three new applicable, HIPAA-compliant revenue codes:

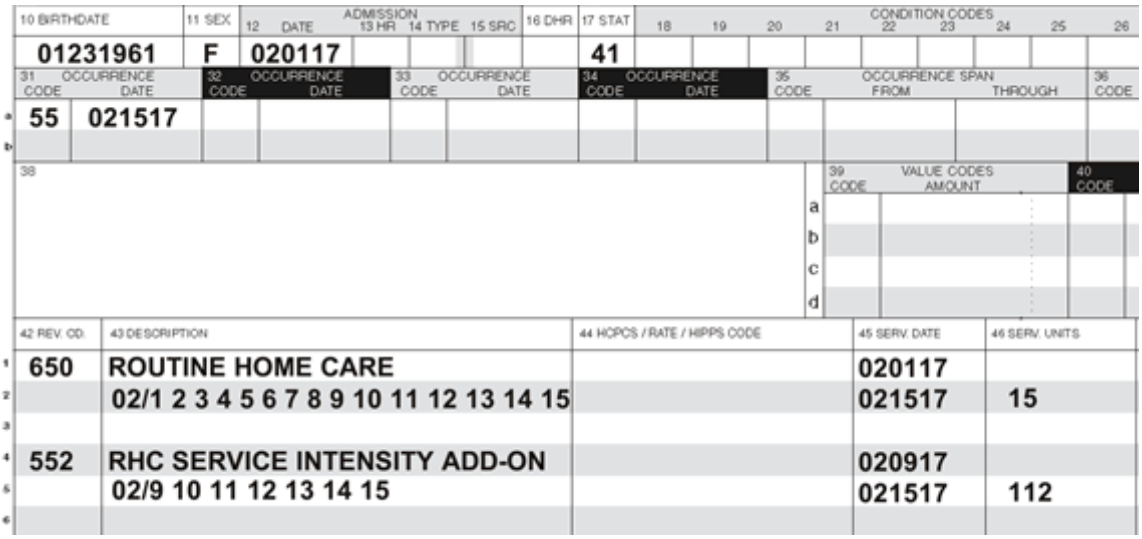
- 0650 (routine home care [high rate])
- 0659 (routine home care [low rate])
- 0552 (routine home care [SIA rate])

Providers are required to make sure that the number of days billed for any per-diem hospice service matches the number of days represented in the from-through service date range.

Upon implementation of this project, providers can void old claims that used the obsolete hospice routine home care revenue code/procedure code (listed below) and resubmit using the new codes described above:

- Claims for routine home care using procedure code Z7100 (routine home care [per diem]) for dates of service January 1, 2016 – May 31, 2016
- Claims for routine home care using revenue code 0651 for dates of service June 1, 2016 – May 1, 2018

Also, providers are requested to complete two additional fields on the outpatient claim form: *Admission Date* (Box 12) and *Status* (Box 17).



10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26
01231961	F	020117					41									

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 CODE
a 55	021517										
b											

38		39 VALUE CODES CODE	AMOUNT	40 CODE
	a			
	b			
	c			
	d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS
1	650	ROUTINE HOME CARE		020117	
2		02/1 2 3 4 5 6 7 8 9 10 11 12 13 14 15		021517	15
3					
4	552	RHC SERVICE INTENSITY ADD-ON		020917	
5		02/9 10 11 12 13 14 15		021517	112
6					

The data captured in these fields will be used to assist Audits and Investigations (A&I) in verifying the validity of routine home care claims. Some applicable data values allowed for the *Status* field (Box 17) are:

- 01 – Discharged to home or self-care
- 30 – Still a patient (for continuing hospice care for same recipient)
- 40 – Expired at home
- 41 – Expired in a medical facility, such as a hospice, Nursing Facility Level A, Nursing Facility Level B, or freestanding hospice
- 42 – Expired – place unknown
- 50 – Discharged/transferred to hospice – home
- 51 – Discharged/transferred to hospice – medical facility

Providers are instructed to include any transfer information for the recipient from their previous hospice stay, including the National Provider Identifier (NPI) of the facility and admission and transfer dates. A&I will address any text placed in the field.

Upon implementation of the new revenue codes, providers will have the following options to void claims and prepare to submit claims with the new codes, effective retroactively for dates of service on or after January 1, 2016:

- Providers requiring a void and subsequent resubmission of a corrected claim use a two-step process. First, a *Claims Inquiry Form* (CIF) void must be submitted to recoup the full payment (see the *CIF Completion* section in the Part 2 manual for details). Indicate *Overpayment* (checkbox). Once the void appears on a future *Remittance Advice Details* RAD, the provider completes the secondary step of submitting an appeal to request processing of the corrected claim. The appeal must be submitted within 90 days to avoid cost cutback or claim denial. Detailed appeal submission and documentation requirements are included in the *Appeal Form Completion* section of the appropriate Part 2 provider manual.
- For providers choosing to void multiple claims at one time, the Department of Health Care Services (DHCS) will perform a one-time collection of National Provider Identifiers (NPIs) following the implementation of the new revenue codes. Once the mass void is complete, appeals may be submitted with the corresponding RAD and the indication in the *Remarks* field (Box 80) of the *UB-04* claim form that the previous claim was voided.

The following is an example series of events for submission of a CIF and appeal for a previously paid singular claim with hospice routine home care procedure code Z7100, for dates of service from January 1, 2016 – May 31, 2016, or revenue code 0651 for dates of service from June 1, 2016 – May 1, 2018:

1. A provider has previously submitted a claim on date of service July 1, 2016, for hospice routine home care service revenue code 0651, which has been adjudicated and the provider has received reimbursement.
2. Upon implementation on May 1, 2018, (revenue code 0650 for high rate, 0659 for low rate, 0552 for SIA), the provider wishes to be reimbursed for those new rate amounts for the previously paid claim.
3. Using the steps and details found in the *CIF Completion* section in the Part 2 manual, the provider requests a void on the previous claim by checking *Overpayment* in the checkbox on the CIF and submitting the paid RAD with the CIF.
4. The DHCS Fiscal Intermediary (FI) receives the CIF, voids the previous claim and the provider receives the voided RAD.
5. Within 90 days, the provider submits the appeal with a voided RAD and corrected/updated claim with the new revenue codes to the DHCS FI for reprocessing.
    a. The provider indicates in the *Remarks* field (Box 80) that the previous claim was voided, along with the reason for the void and expectation to be reimbursed at the new routine home care rates.
    b. The appeal is submitted within 90 days of the submission date on the voided RAD.

6. The reprocessing of the updated claim occurs and reimbursement finalizes, as appropriate, with the new rates.*

The following is an example series of events for submission of a mass void of many previously paid claims with hospice routine home care procedure code Z7100, for dates of service from January 1, 2016 – May 31, 2016, or revenue code 0651 for dates of service from June 1, 2016 – May 1, 2018:

1. A provider previously submitted 100 claims for dates of service from January 1, 2016 – May 31, 2016, for hospice routine home care service procedure code Z7100, which have been adjudicated and the provider has received reimbursement.

2. Upon implementation on May 1, 2018, (revenue code 0650 for high rate, 0659 for low rate, 0552 for SIA), the provider wishes to be reimbursed for the new rate amounts for the previously paid claims.

3. The provider compiles all Claim Control Numbers (CCNs) and their NPI for each previously reimbursed claim and sends this list to HospiceEPC@conduent.com before July 1, 2018. At that time, CCNs will be submitted for a mass void. **Providers should note that this process is subject to scheduling and may take up to six months for completion.**

4. A mass void occurs for all the submitted CCNs, and the provider receives the voided RADs.

5. Within 90 days, the provider submits the appeal with a voided RAD and corrected/updated claim with the new revenue codes to the DHCS FI for reprocessing.

    a. The provider indicates in the *Remarks* field (Box 80) that the previous claim was voided, along with the reason for the void and expectation to be reimbursed at the new routine home care rates.

    b. The appeal is submitted within 90 days of the submission date on the voided RAD.

6. The reprocessing of the updated claim occurs and reimbursement finalizes, as appropriate, with the new rates.*

*Disclaimer: During this CIF/resubmission process, once the original claim has been voided, the original reimbursement will be taken back. Providers should account for this until the reprocessed claim is adjudicated and the new reimbursement occurs, as appropriate.

This information is reflected in the following provider manual(s):

Provider Manual(s)	**Page(s) Updated**
AIDS Waiver Program	aids (13); medi non hcp (2)
Audiology and Hearing Aids Chronic Dialysis Clinics Durable Medical Equipment Heroin Detoxification Home Health Agencies/Home and Community-Based Services Medical Transportation Obstetrics Orthotics and Prosthetics Pharmacy Psychological Services Rehabilitation Clinics Therapies Vision Care	medi non hcp (2)
Clinics and Hospitals General Medicine	hospic (7–9, 12); medi non hcp (2)
Hospice Care Program	hospic (7–9, 12); hospic bil cd (1, 2); hospic ge (2, 4); medi non hcp (2)
Inpatient Services	hospic (7–9, 12)