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Home and Community-Based Care (Waiver) Regulatory Changes

Assisted Living Facility Providers

Purpose

Effective March 1, 2011, new regulations under 7 AAC 145.520:

- Were adopted for Alaska Medicaid waiver providers
- Support changes to claim payment methodology
- Use a matrix which includes a single regional rate for each servicing location
- Adjust the reimbursement rates for inflation and to reflect differences in the cost of doing business in various regions across Alaska



Frequently Used Terms

- **Average Allowed Amount (AAA)** - 3 month average of claims submitted from July 1, 2009 through September 30, 2009 and processed before February 3, 2010
- **Established Rate (ER)** - rates established in the department's *Chart of Personal Care Attendant and Waiver Services Rates*. Service rates on the chart will be adjusted to reflect regional differences in the cost of doing business based on the region in which the provider is located [7 AAC 145.520(g)(2)]
- **Recipient Care Rate (RCR)** - reimbursement rate after phase-in calculations, if applicable, using average allowed amount and established rate
- **Office of Rate Review (ORR)** - establishes Medicaid payment rates for hospitals, nursing facilities, home health agencies, ambulatory surgical centers, rural health clinics, and federally qualified health centers. They also work with tribal providers and various divisions and units throughout the DHSS on rate setting and accounting issues.



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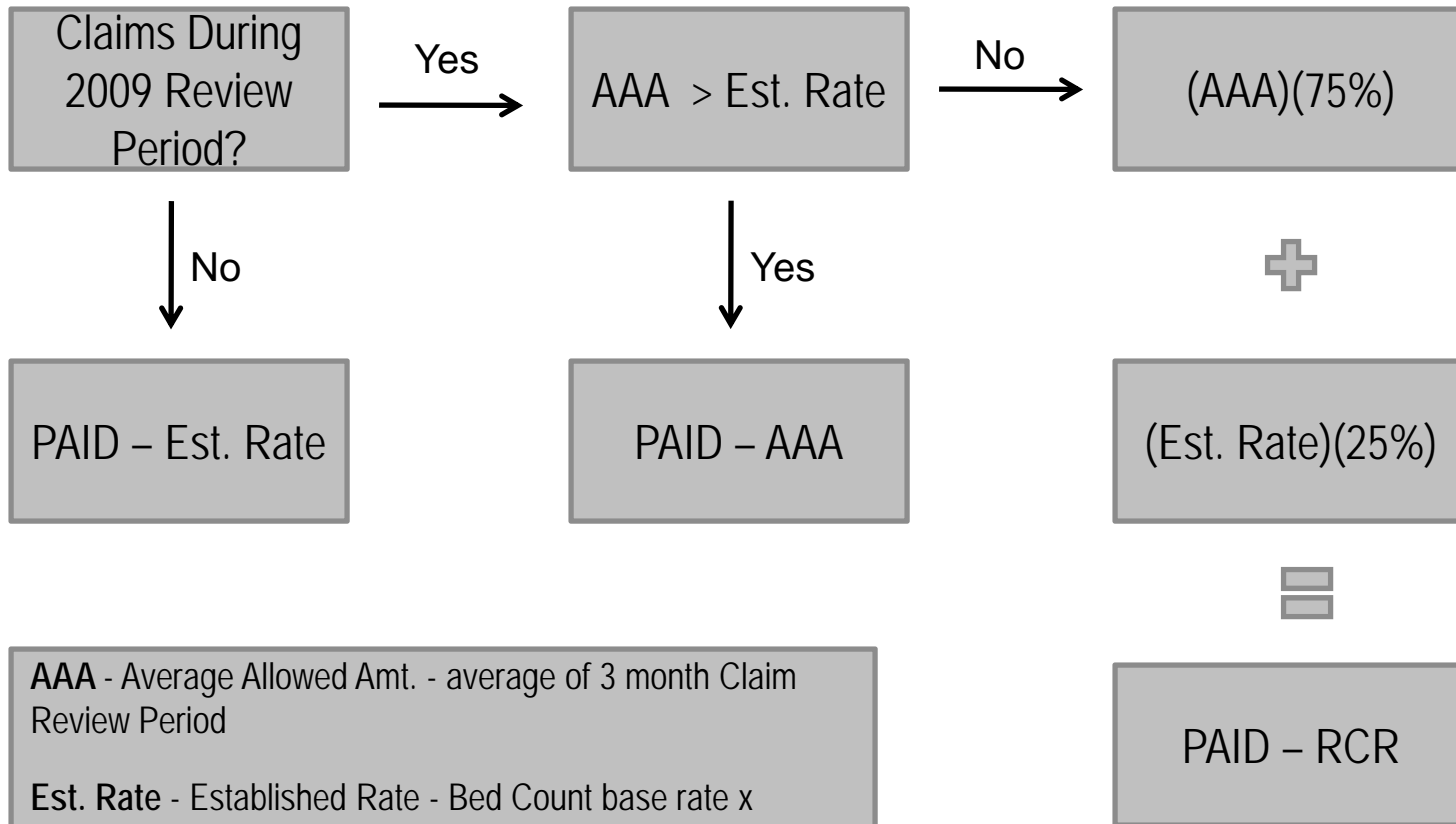
Rate Determination

In accordance with 7 AAC 145.520, there will be a phase-in period to reach 100% of the regional rate payment methodology. This will only apply to Alaska Medicaid waiver providers who:

- Actively submitted claims from July 1, 2009 through September 30, 2009 that processed before February 3, 2010
 - Referred to as "Average Allowed Amount"
- Received an "Average Allowed Amount" and that amount is less than the established rate [7 AAC 145.520(h)(1)]



Flow Chart – Claims Before July 1, 2011



AAA - Average Allowed Amt. - average of 3 month Claim Review Period

Est. Rate - Established Rate - Bed Count base rate x Regional Adjustment

RCR - Recipient Care Rate - reimbursement rate after phase-in calculations, if applicable, using average allowed amount and established rate



Rate Determination

In accordance with 7 AAC 145.520, there will be a “phase-in period” to reach 100% of the regional rate payment methodology:

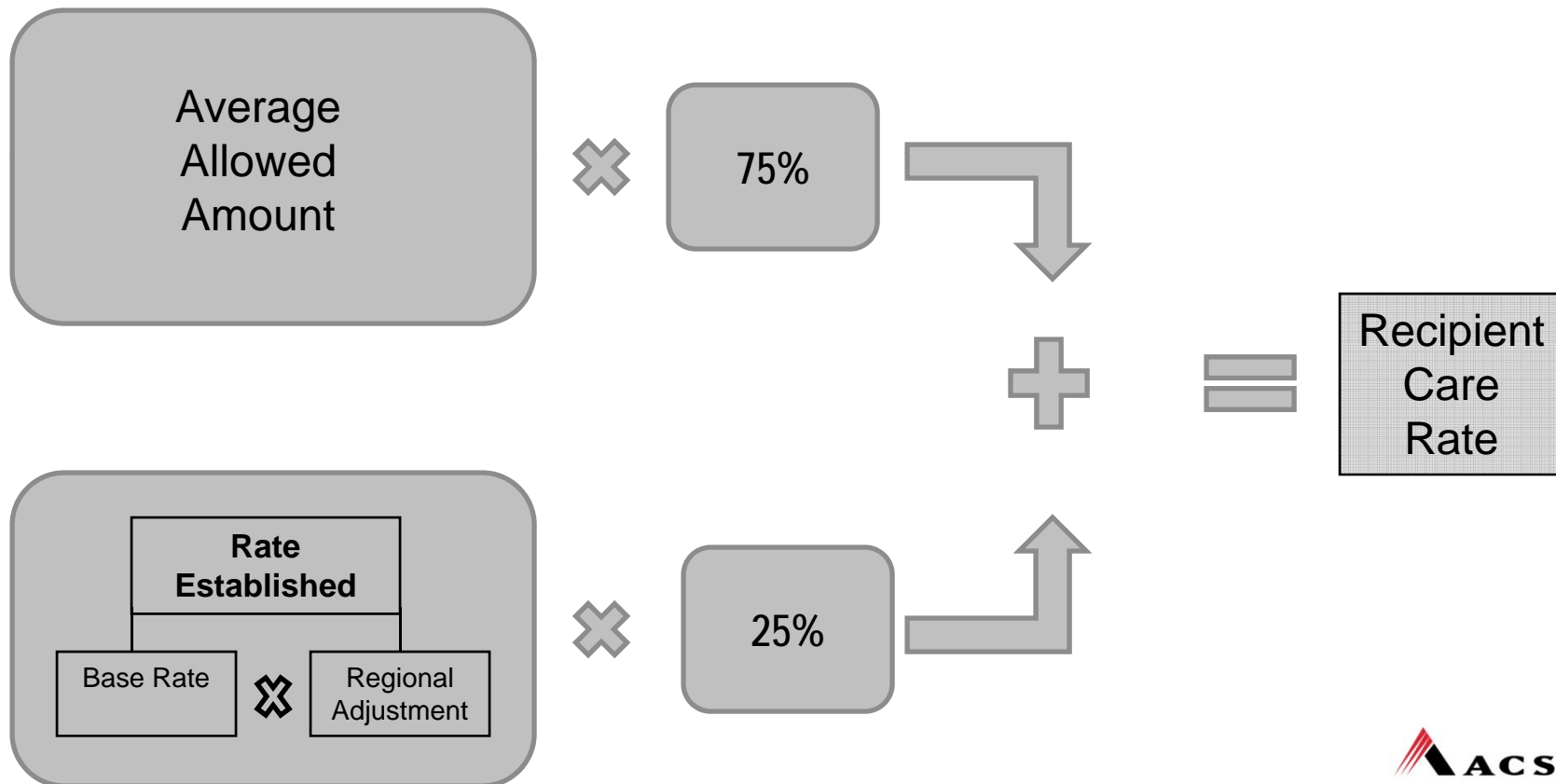
- Before July 1, 2011, the rate will be calculated as 75% of the average allowed amount plus 25% of the established rate
- After June 30, 2011 and before July 1, 2012, the rate will be calculated as 50% of the average allowed amount plus 50% of the established rate
- After June 30, 2012 and before July 1, 2013, the rate will be calculated as 25% of the average allowed amount plus 75% of the established rate
- After June 30, 2013, paid at 100 percent of the established rate



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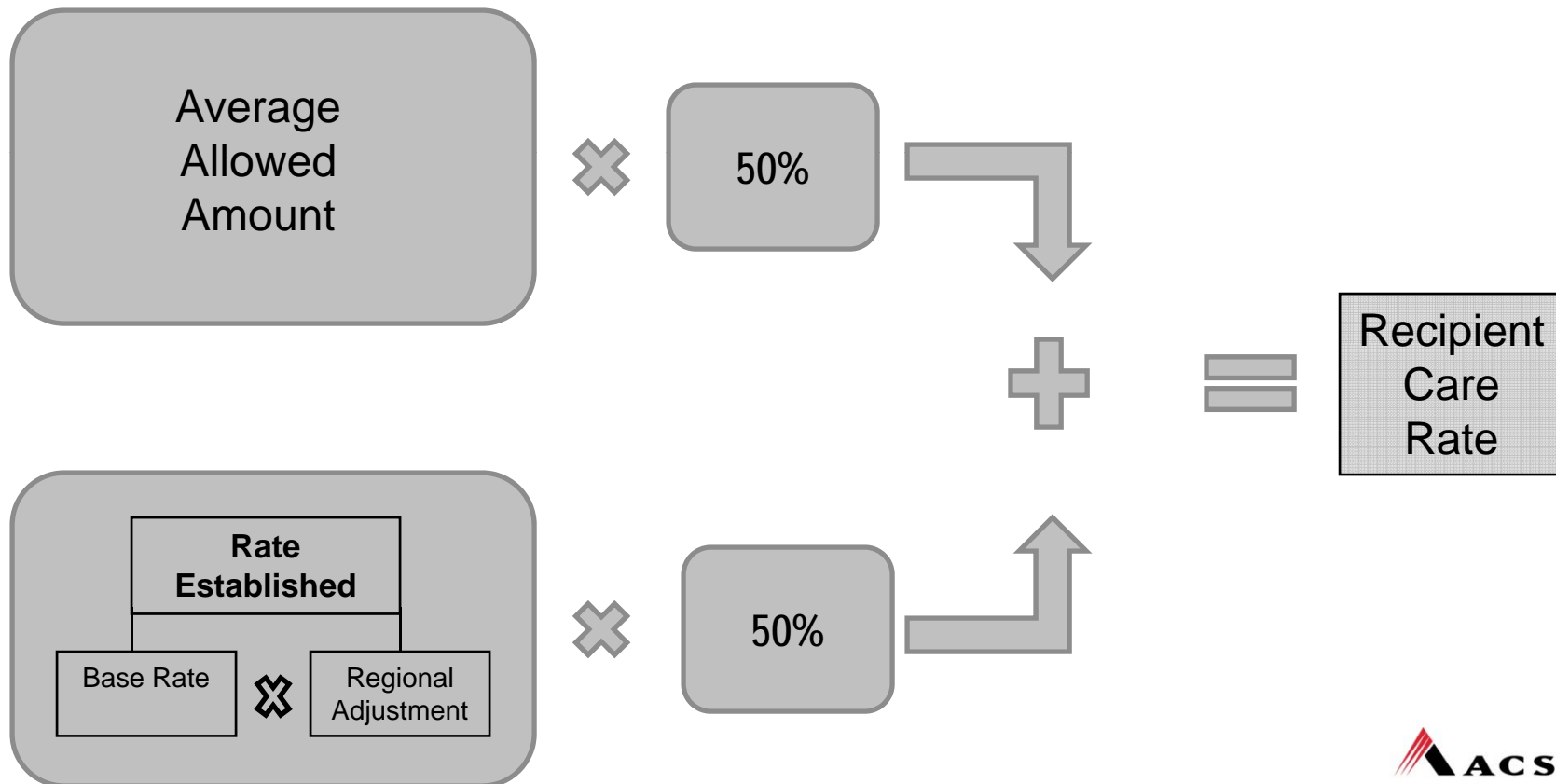
Rate Determination

Before July 1, 2011, if the provider's average allowed amount is lower than the rate established, the recipient care rate will be calculated as follows [7 AAC 145.520(h)(2)(A)]:



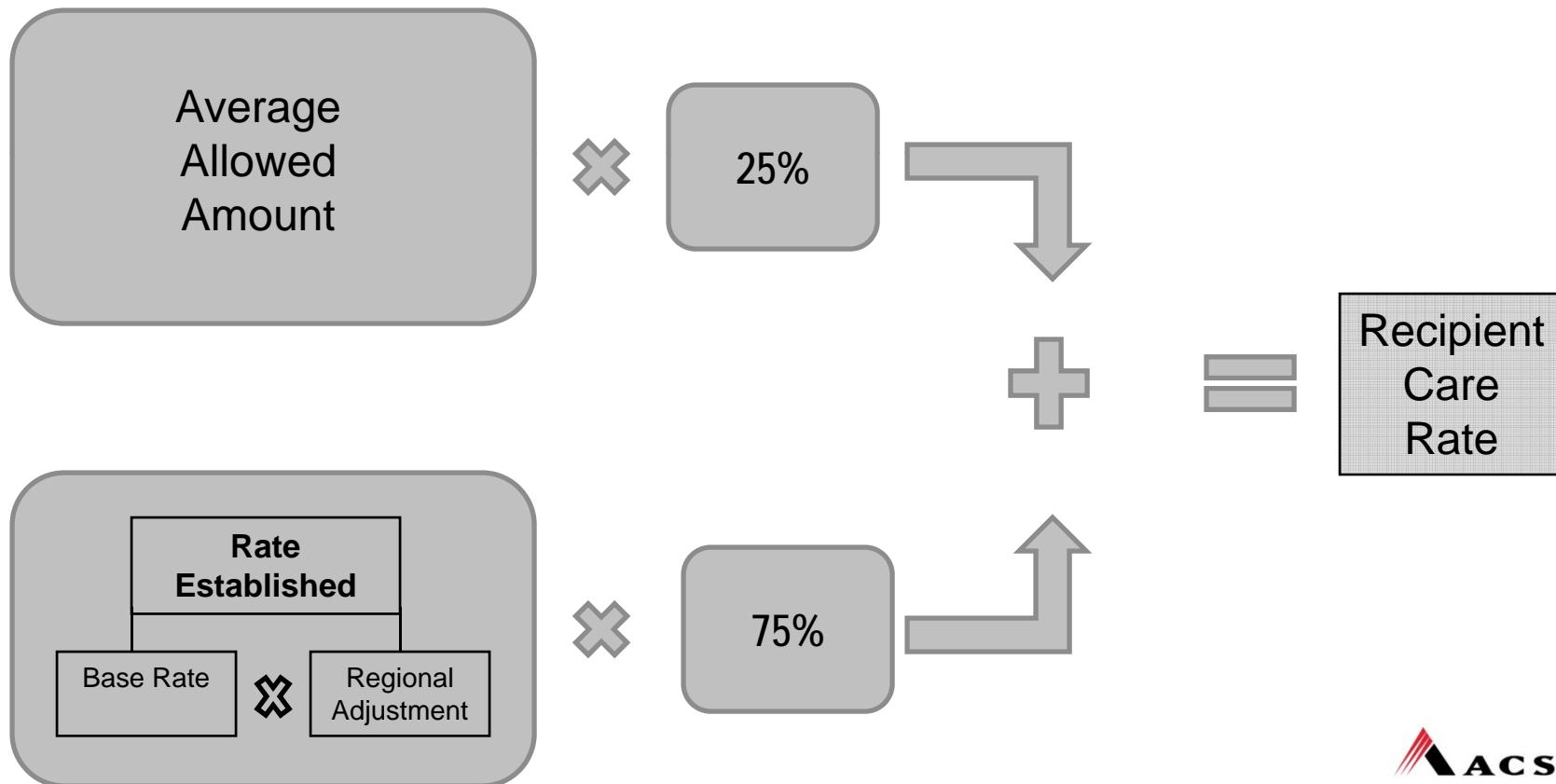
Rate Determination

After June 30, 2011 and before July 1, 2012, if the provider's average allowed amount is lower than the rate established, the Recipient Care Rate will be calculated as follows (7 AAC 145.520(h)(2)(B):



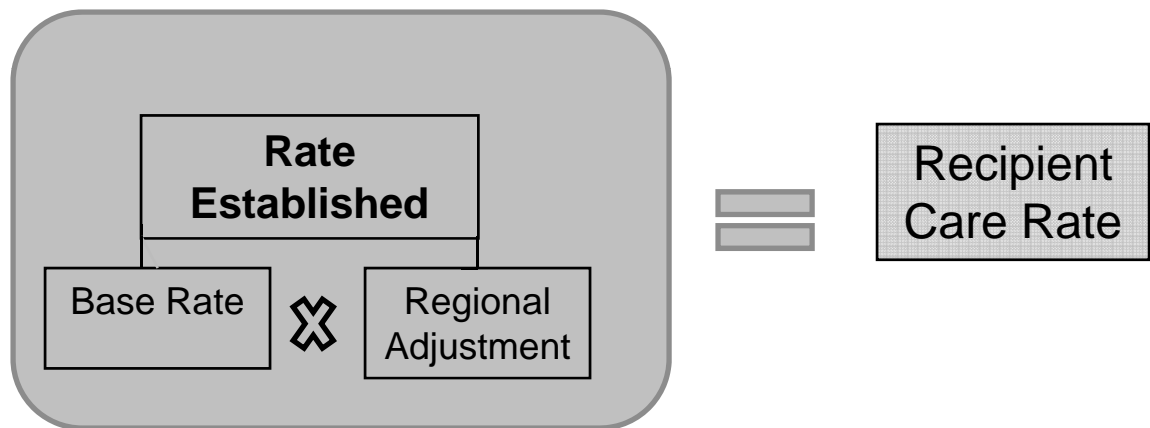
Rate Determination

After June 30, 2012 and before July 1, 2013, if the provider's average allowed amount is lower than the rate established, the recipient care rate will be calculated as follows [AAC 145.520(h)(2)(C)]:



Rate Determination

After June 30, 2013, all providers will receive 100% of the rate established for services, regardless of former rates received [7 AAC 145.520(h)(2)(D)]:



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Provider Notice – Bed Capacity Range Notice

- Division of Public Health maintains licensing information on provider bed capacity
- Bed capacities are determined per business entity
 - Each servicing location's enrollment record reflects total number of approved beds the business entity possesses
- Notice is generated when provider's record is updated with bed capacities
- Bed capacities determine proper modifier to be used when billing procedure code T2031



Provider Notice – Bed Capacity Range Notice

- Notice provides effective dates of service for specific modifier
- Updated notice generated if bed capacities change, requiring a different modifier for billing
- Providers should not bill Alaska Medicaid until they have received this notice
 - Claims will deny for edit 515 if modifier on claim does not match modifier on the provider enrollment record
- Notices must be kept with billing records



Provider Notice – Bed Capacity Range Notice

Dear Assisted Living Provider [RLXXXXX]:

An update has been made to the facility bed capacity range on your Alaska Medicaid enrollment file. This update is the result of an identified change in number of approved assisted living facility beds for your business entity.

You will need to make changes to claims billed to Alaska Medicaid for your Assisted Living facility services to reflect this change in total approved beds. When billing for standard Adult Residential services using procedure code T2031 for dates of service on or after [EFFECTIVE DATE], the procedure code modifier on your claim must be:

___ UR (5 or fewer total beds)

___ US (6-16 total beds)

___ no procedure code modifier (17 or more beds)

Any claims submitted for standard Adult Residential services for dates of service on or after the above-stated effective date of service that do not contain the above-listed modifier information will be denied.

Also, the dates of service on any Adult Residential service claim cannot span across this effective date, as pricing cannot be determined when the service dates span more than one service rate. If a claim is submitted with a From Date less than the above-stated effective date of service and a Thru Date greater than or equal to the above-stated effective date of service, it will be denied.

Keep this notice for your billing records. You will receive future notices of changes to your approved bed count. You will need to change your billing modifier when you receive these notices.

If you have any questions about how to properly bill these services, please contact the ACS Provider Inquiry staff at 907-644-6800, option 1, 1.



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Billing Instructions – Procedure Code Modifier

- **UR** (5 or fewer total beds)
- **US** (6-16 total beds)
- No procedure code modifier (17 or more total beds)
- The appropriate procedure code modifier as noted on your “Bed Capacity Range” notice is required in field 24 D

Example of an entity with 5 or fewer total approved beds

24.	A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES
	From			To					(Explain Unusual Circumstances)			
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER		
1	03	01	11	03	31	11			T2031	UR		

Example of an entity with 17 or more total approved beds

24.	A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES
	From			To					(Explain Unusual Circumstances)			
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER		
1	06	01	12	06	30	12			T2031			



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Billing Instructions – Span-Dates Cannot Cross Service Rates

- Providers **will not** be allowed to submit a claim line with dates of service that cross February 28th and March 1st, 2011
- Any services rendered on or after March 1, 2011 should be billed separately from services rendered prior to this date
- Claim lines that span February and March 2011 service dates will be denied
- Claim lines spanning service rates will deny for Edit 095 - *Cannot span-date bill across different pricing methodologies*

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES
	From	To							CPT/HCPCS	MODIFIER		
MM	DD	YY	MM	DD	YY							
1	02	17	11	02	28	11						

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES
	From	To							CPT/HCPCS	MODIFIER		
MM	DD	YY	MM	DD	YY							
1	03	01	11	03	31	11						



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Billing Instructions – Span-Dates Cannot Cross Service Rates

- Providers **will not** be allowed to submit a claim line with dates of service that cross service rates
- Claim lines spanning service rates will deny for Edit 095 - *Cannot span-date bill across different pricing methodologies*
- If there is a change in an entity's total bed capacity resulting in the use of a different modifier, the provider must bill each modifier and corresponding date of service on a separate claim line
- An **updated** "Bed Capacity Range" notice will be sent to the provider notifying them of the new modifier and effective dates to use when billing



Billing Instructions – Span-Dates Cannot Cross Service Rates

- For example, if an entity possess 4 beds (modifier UR) during the month of March 2011, and then is approved for an additional 5 beds beginning April 1, 2011, the total bed count for April would be 9 beds (modifier US)

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES
	From	To			(Explain Unusual Circumstances)							
	MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER			
1	03	01	11	03	31	11		T2031	UR			
2	04	01	11	04	30	11		T2031	US			



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Billing Instructions – Servicing ZIP + 4

- With the new payment methodology changes now including regional rate adjustments, it is very important that providers put the servicing facility ZIP code + 4 in field 32

1	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSOT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
	From	To	MM		DD				YY								
1	03	01	11	03	31	11			T2031	UR						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? <small>For priv. contracts, see back.</small>		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
			<input type="checkbox"/>		<input type="checkbox"/>					<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		\$		\$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small>							32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # (907) 644-6800						
							ACS ALH 1835 S. Bragaw St. Anchorage, AK 99504 - 3469				ACS ALH 1835 S. Bragaw St. Anchorage, AK 99504 - 3469						
SIGNED			DATE			a.			b.			c.			d.		
									1234567890								

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)



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Billing Instructions – Acuity Rate

- A qualified recipient is one with an approved plan of care under 7 AAC 130.230 which documents the recipient receives dedicated one-on-one staffing care 24 hours per day
- Qualified recipients receiving residential supported-living services (T2031) under 7 AAC 130.255 *are eligible for an acuity rate of \$320 per approved day, in addition* to the qualified recipient's daily rate **if** the service receives prior authorization by the Division of Senior and Disabilities Services (SDS)
- These services **must** be billed on two claim lines; one line for the recipient care base rate (T2031) and one line for the acuity rate add on (T2031 with TG modifier)

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES
	From			To					(Explain Unusual Circumstances)			
	MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER			
1	03	01	11	03	31	11		T2031	UR			
2	03	01	11	03	31	11		T2031	TG			



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Billing Instructions – Payerpath™

Procedure Code Modifier:

- UR (5 or fewer total beds)
- US (6-16 total beds)
- No procedure code modifier (17 or more total beds)
- The appropriate procedure code modifier as noted on your “Bed Capacity Range” notice is required in “Field 24: Mod1”

	From Date	To Date	POS	TOS	HCPCS	Mod1	Mod2	Diag code	Charges	Units	FP	EMG	COB	Reserved	NPI	Del
1	03/01/11	03/30/11			T2031	UR										
2																
3																
4																
5																
6																



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Billing Instructions – Payerpath™

Servicing ZIP + 4:

- With the new payment methodology changes now including regional rate adjustments, it is very important that providers put the servicing facility ZIP code + 4 in field 32: Facility Name

25. FED TAX ID: <input type="text"/> ID TYPE: <input type="checkbox"/> Emp=24 SSN=34	26. PAT ACCT # <input type="text"/>	27. ACCEPT? <input type="checkbox"/> Assigned=A Not Assigned=C	28. TOT CHARGE <input type="text"/>	29. AMT PAID <input type="text"/>	30. BAL DUE <input type="text"/>
31. SIGNATURE OF PHYSICIAN <input type="text"/> <input type="text"/> <input type="text"/>	32. FACILITY NAME ACS ALH 1835 S. Bragaw St. Anchorage AK 99504-3469		33. BILLING NAME ACS ALH 1835 S. Bragaw St. Anchorage AK 99504-3469		
	32. FACILITY NPI <input type="text"/>		33. BILLING PROV ID <input type="text"/>	RESERVED FOR LOCAL USE <input type="text"/>	NPI <input type="text" value="1234567890"/>



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Billing Instructions – Payerpath™

Acuity Rate

- A qualified recipient is one with an approved plan of care under 7 AAC 130.230 which documents the recipient receives dedicated one-on-one staffing care 24 hours per day
- Qualified recipients receiving residential supported-living services (T2031) under 7 AAC 130.255 *are eligible for an acuity rate of \$320 per approved day, in addition to the qualified recipient's daily rate if approved by SDS*
- These services **must** be billed on two claim lines; one line for the recipient care base rate (T2031) and one line for the acuity rate add on (T2031 with TG modifier)

	From Date	To Date	POS	IUS	HCPCS	Mod1	Mod2	Diag code	Charges	Units	FP	EMG	COB
1	03/01/11	03/30/11			T2031	UR							
2	03/01/11	03/30/11			T2031	TG							



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Cost Survey Annual Report

- Providers must submit an annual report no later than nine months after the end of the provider's fiscal year
- Providers who do not submit the report (or who do not meet all of the outlined requirements of the report) will be subject to a payment reduction of up to 20% on all services
- 7 AAC 145.531 - 7 AAC 145.537 provides the details of what should be included in the cost survey report, the allowable and nonallowable costs as well as the record-keeping requirements
- Office of Rate Review will notify the Division of Health Care Services when a penalty is given and the effective dates of payment associated with it



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New Edits

- Edit 095 - Cannot span date bill across different pricing methodologies (Deny)
- Edit 515 – Claim modifier does not match to provider’s bed range modifier for dates of service (Deny)
- Edit 516 – No bed range on provider file (Pend)
 - Claims will pend for 60 days and then deny for edit 517 if bed range is not added to provider file.
- Edit 517 – No bed range on provider file (Deny)



Eligibility Reminder

Before rendering services, verify that the patient is eligible for Alaska Medical Assistance by using one of the following options:

Option	Method
Medical Assistance Coupon	Check "Elig. Month" to determine coverage
Medical Assistance Card	Check Coverage Effective Dates
Eligibility Verification System (EVS)	Call (800) 884-3223
By Fax	Send Recipient Eligibility Fax form to ACS
By Phone	Call (907) 644-6800 or (800) 770-5650



Billed Charges Rule Reminder

- 7 AAC 145.005(h)(2) directs providers on their allowed billed charges:
- A provider may not charge a higher rate for any unit of service provided to a Medicaid recipient than the provider charges others, except for an amount billed Medicare



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Need More Help?

- <http://medicaidalaska.com>
 - Choose “Providers” then “HCBC Waivers”
 - Necessary information for successful billing
 - Access to billing manuals and fee schedules
- By phone:

Department	Anywhere (907) 644-6800	Toll-Free in AK (800) 770-5650
Billing/Coverage/Claim Status	Option 1	Option 1 > 1
EDI/Payerpath	Option 3	Option 1 > 4
Provider Inquiry	Option 1	Option 1 > 1



Preparing for HIPAA 5010

- Centers for Medicare and Medicaid Services (CMS) Standard
- 5010 Implementation January 1, 2012
- Regulate Electronic Transmission of Healthcare Transactions
- 5010 Transactions Testing



Preparing for ICD-10

- Center for Medicare and Medicaid Services (CMS) Mandate
- Two components
 - ICD-10-CM Diagnosis Codes
 - ICD-10-PCS Institutional Procedure Codes
- Service Date Driven
 - Outpatient Claims
 - Inpatient Claims
- Prepare Now



Resources

- CMS ICD-10 Website
- <http://www.cms.gov/ICD10/>
- Affiliated Computer Services (ACS) Alaska Medical Assistance Website
- <http://medicaidalaska.com>



Resources

- CMS 5010 D.0 Websites
 - <http://www.cms.gov/Versions5010andD0/>
 - <http://www.cms.gov/MFFS5010D0/>
- Affiliated Computer Services (ACS) Alaska Medical Assistance Website
 - <http://medicaidalaska.com>



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