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# Home and Community-Based Agency Regulatory Changes

# 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)]



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# Frequently Used Terms

- **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
- **Intensive Active Treatment (IAT)\*** - refers to any type of treatment or therapy as identified in an individual's plan of care, and which is scheduled for a limited period of time. It is designed to maintain or improve the recipient's overall level of functioning

\* Billing rules represented in this presentation are for regulations that went into effect 3/1/11. New billing rules will be forthcoming for the court-ordered delay.



# 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:

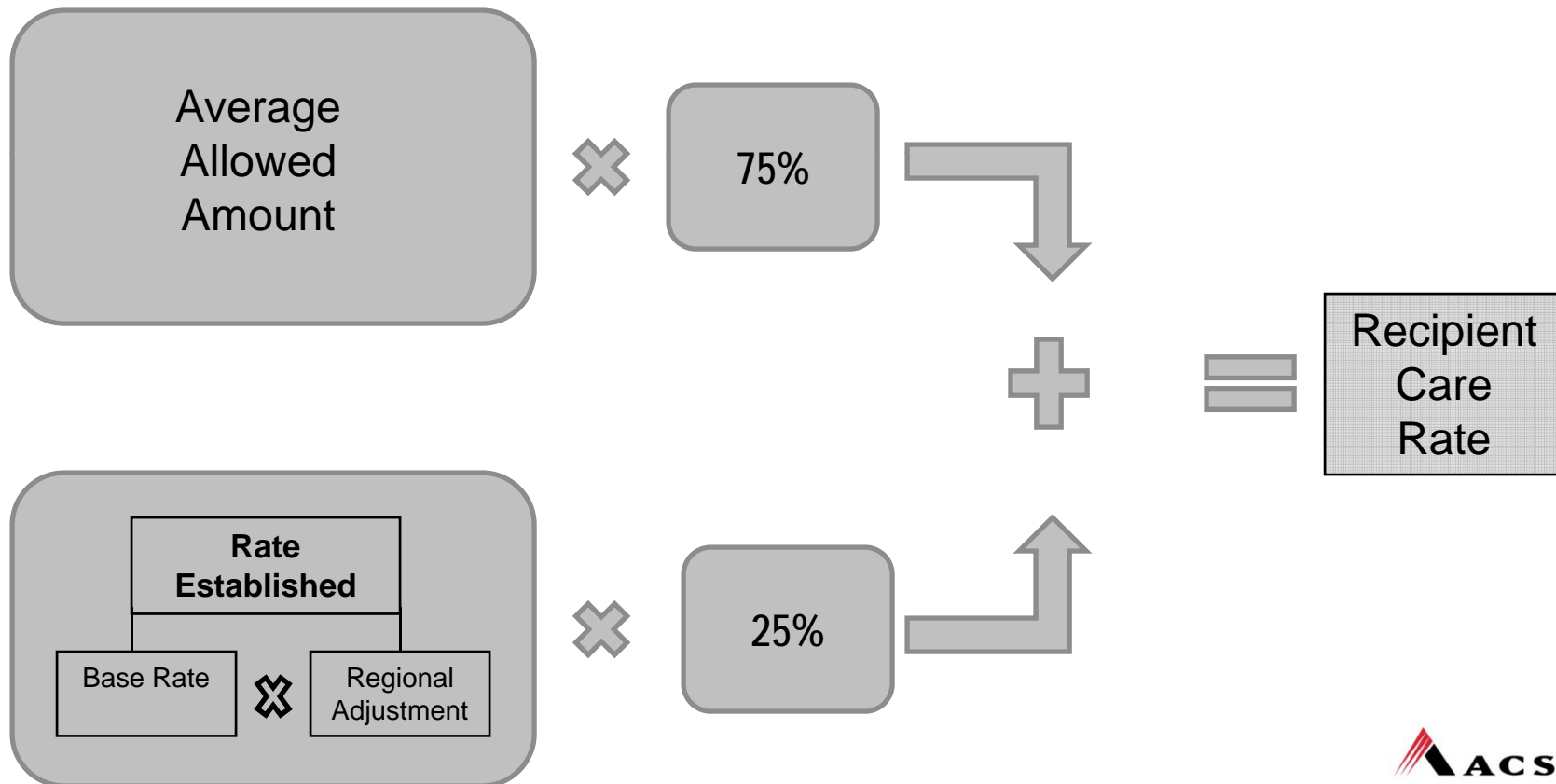
- Before July 1, 2011, the rate will be calculated as 75% of the average allowed amount plus 25% of the established rate
- After June 30, 2011 and before July 1, 2012, the rate will be calculated as 50% of the average allowed amount plus 50% of the established rate
- After June 30, 2012 and before July 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
- **Note:** “Phase-In” will **not** apply to Intensive Active Treatment Services\*

\* Billing rules represented in this presentation are for regulations that went into effect 3/1/11.  
New billing rules will be forthcoming for the court-ordered delay.



# Rate Determination

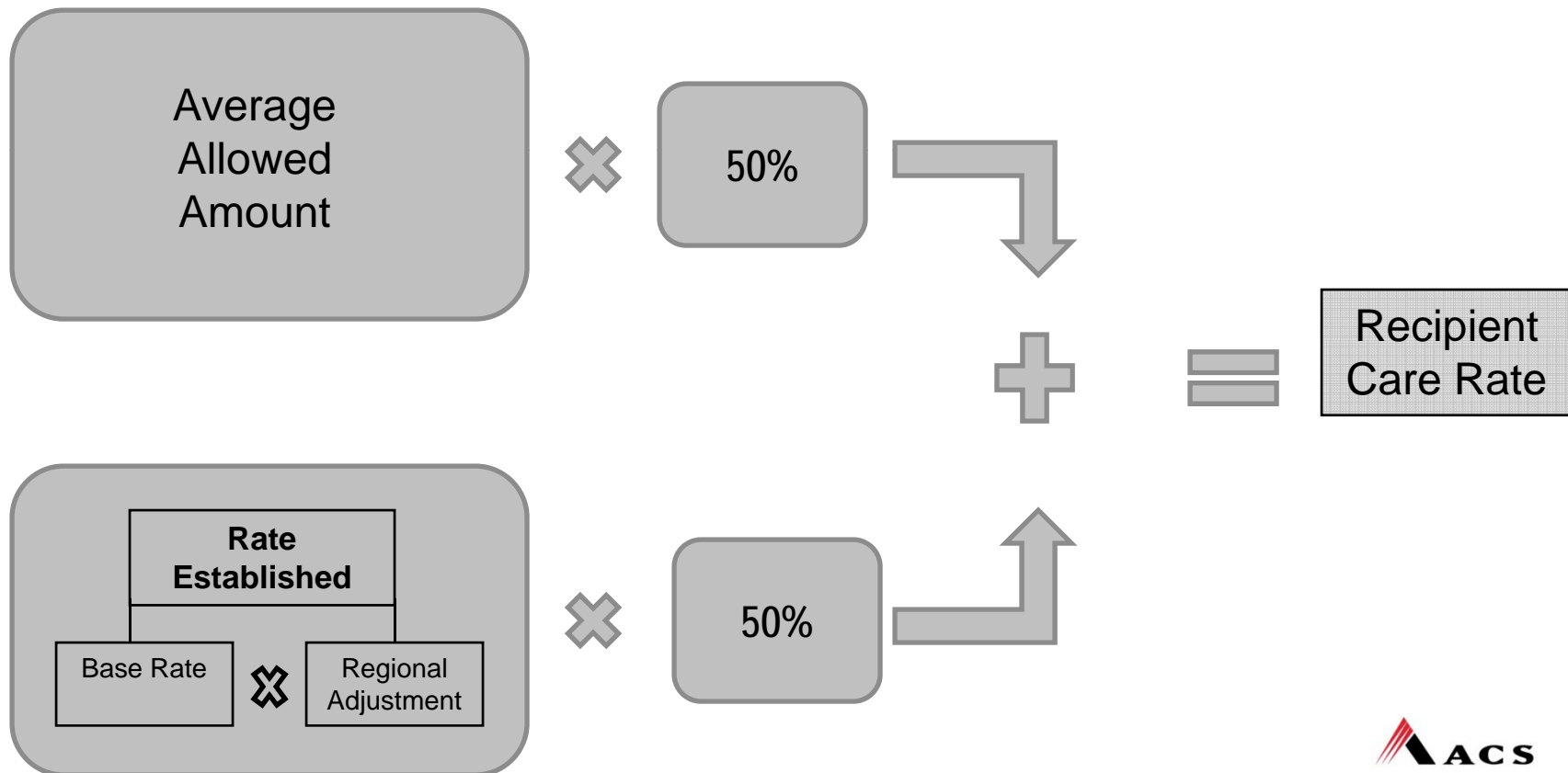
**Before July 1, 2011**, if the provider's average allowed amount is lower than the rate established, the recipient care rate will be calculated as follows [7 AAC 145.520(h)(2)(A)]:



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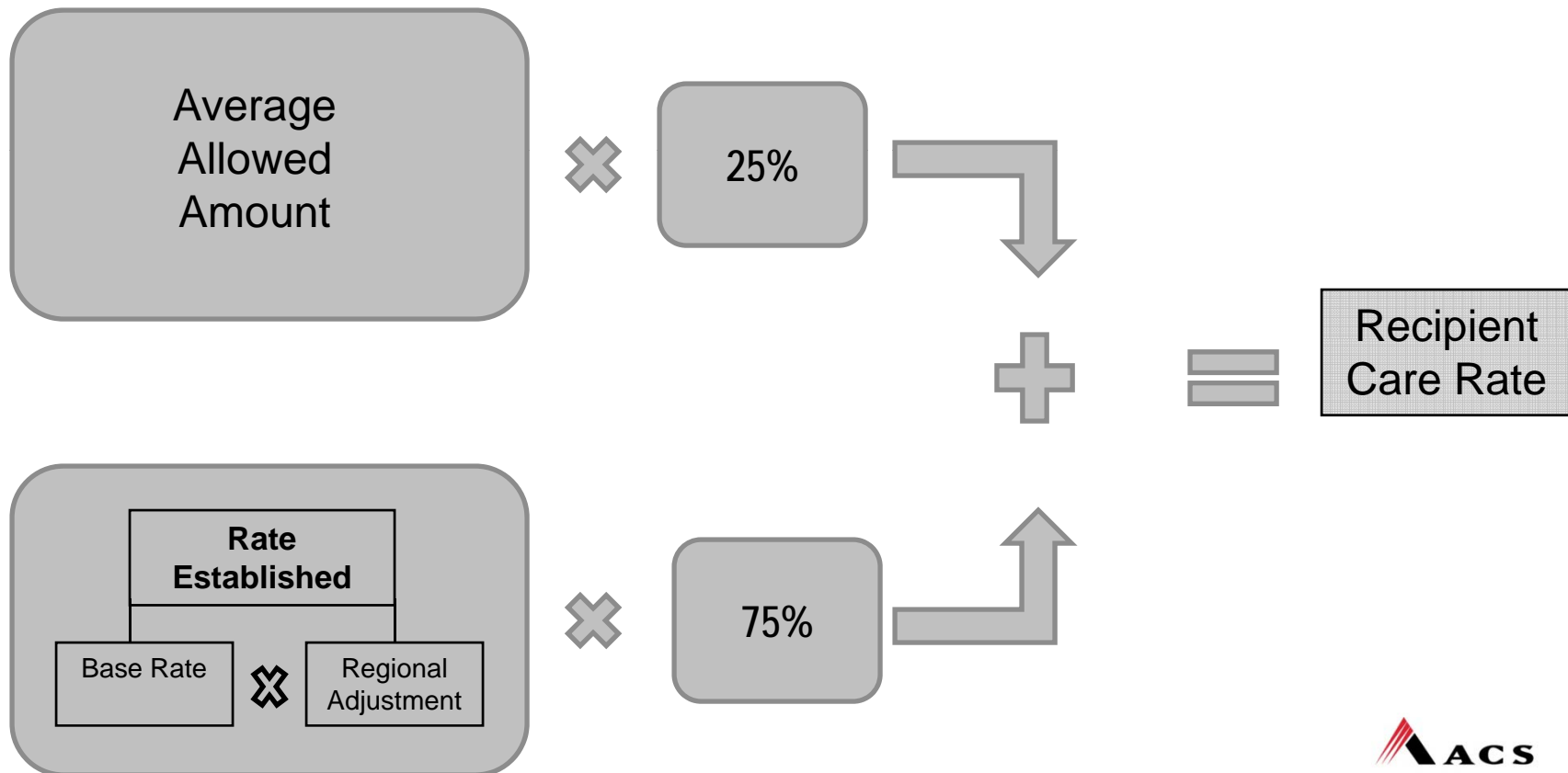
# Rate Determination

**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):



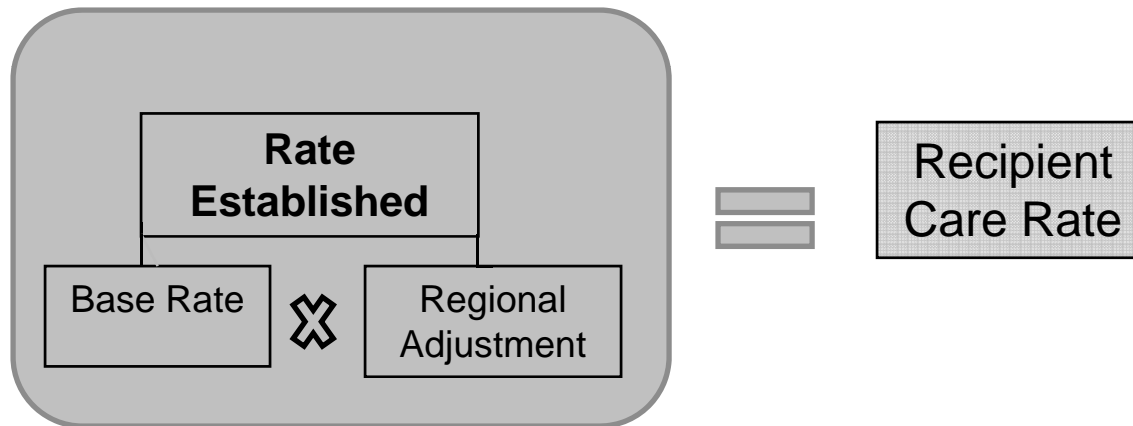
# Rate Determination

**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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# 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 28<sup>th</sup> and March 1<sup>st</sup>, 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 MM DD YY	To MM DD YY	CPT/HCPCS	MODIFIER								
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 MM DD YY	To MM DD YY	CPT/HCPCS	MODIFIER								
1	03	01	11	03	31	11						



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# Billing Instructions – Acuity Rate

- Qualified recipients receiving group home habilitation services (T2016) under 7 AAC 130.265 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)
- 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
- These services **must** be billed on two claim lines; one line for the recipient care base rate (T2016) and one line for the acuity rate add on (T2016 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	11	11	03	11	11		T2016				
2	03	11	11	03	11	11		T2016	TG			



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# Billing Instructions – Procedure Code Modifiers

Modifier U2 or U4 is now required when billing IAT\* services (T2034) or Nursing Oversight and Care Management (T1016):

- **U2 – Local** (Less than 200 miles from facility to recipient’s residence)
- **U4 – Non-Local** (Greater than 200 miles from facility to recipient’s residence)
  - Non-local (greater than 200 miles) means the provider must travel to the recipient in excess of 200 miles
  - T1016 and the modified T2034 15-minute unit codes
- The appropriate procedure code modifier is required in field 24 D

## Example

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			
03	11	11	03	11	11			T2034	U2			

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# Billing Instructions – Span-Dates Cannot Cross Service Rates

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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	27	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	02	11						



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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 MM DD YY	To MM DD YY	EXPLAIN UNUSUAL CIRCUMSTANCES	CPT/HCPCS	MODIFIER													
1	03	01	11	03	01	11			T2016									
2																		
3																		
4																		
5																		
6																		
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						1234567890									

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



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# Billing Instructions – Payerpath™

## Acuity Rate

- Qualified recipients receiving group home habilitation services (T2016) under 7 AAC 130.265 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 SDS
- 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
- These services **must** be billed on two claim lines; one line for the recipient care base rate (T2016) and one line for the acuity rate add on (T2016 with TG modifier)

	From Date	To Date	POS	TOS	HCPCS	Mod1	Mod2	Diag code	Charges	Units	FP	EMG	COB
1	03/11/11	03/11/11			T2016								
2	03/11/11	03/11/11			T2016	TG							



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# Billing Instructions – Payerpath™

Modifier U2 or U4 is now required when billing IAT\* services (T2034) or Nursing Oversight and Care Management (T1016):

- **U2 – Local** (Less than 200 miles from facility to recipient's residence)
- **U4 – Non-Local** (Greater than 200 miles from facility to recipient's residence)
- "Non-local" (greater than 200 miles) means the provider must travel to the recipient in excess of 200 miles
  - T1016 and the modified T2034 15-minute unit codes
- The appropriate procedure code modifier 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	03/11/11	03/11/11			T2034	U4										
2																
3																

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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"/> 1234567890



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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



# Edits

- **New Edit 095** - Cannot span date bill across different pricing methodologies
  - Claims will deny as pricing cannot be determined
- **Updated Edit 316** – **Modifier not valid** for this **procedure**
  - Valid modifiers are U2, U4, or TG as discussed previously in this presentation



# 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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# 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>

# 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





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