Elderly Waiver Providers

MEDICA®

AGENDA

- Getting Set Up as an Elderly Waiver (EW) Provider
- The Role of the Care Coordinator
- Prior Authorizations
- The Claim Submission Process
- Claim Appeals and Adjustments
- Resources and Upcoming Trainings

Definition of an EW Provider

Elderly Waiver Provider

Elderly Waiver (EW) services is 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 person's individual needs and choices. EW offers services that go beyond what is available through Medical Assistance.

Definition of an Elderly Waiver Provider

Provider Types

- The following provider types can bill Elderly Waiver Codes:
  - Elderly Waiver
  - Home Health Care Agency
  - PCA Agency
  - Skilled Nursing Facility
- The following plan types have elderly waiver benefits
  - MSHO
  - MSC+

Getting Set up as an EW Provider

Getting Set up as an EW Provider

- If the provider who wants to bill an elderly waiver code is not a contracted provider, they should call the PSC to be set up as a non-contracted provider
- Providers need to be registered with the Minnesota Department of Human Services in order to be set up as a Medica provider
- Providers will need to send a copy of their W9 to the PSC representative to complete set up as well as fill out an Out of Network Provider Set Up Form
- Once the provider is set up (average turn-around-time is 10-14 business days), they can begin submitting claims

Just because a provider is set up to bill Elderly Waiver Services does not mean they are contracted with Medica

The Role of the Care Coordinator

The Role of the Care Coordinator

- Care Coordinators help members by bringing together different specialists who's help the member may need
- Care Coordinators are also responsible for getting authorizations for certain services prior to them being administered
- Care Coordinators can also assist members with:
  - Paperwork, housing, local food banks, emergency funding, and other activities
  - Coordinating their medical and mental health appointments, meeting them to provide advocacy if necessary
  - Transportation to and from appointments, coordinating with Medica Provide-A-Ride and other sources
  - Disease prevention management
  - And more

The Role of the Care Coordinator Continued

- All MSHO and MSC+ members are assigned a care coordinator who is familiar with the area where the member lives
- If a provider needs to determine who the member's care coordinator is, they can call the Provider Service Center at **1-800-458-5512**
- Different types of services require different types of authorizations – some require specific prior authorizations for claims to pay, while others only require verbal authorization from the care coordinator

EW Authorizations

Section/Topic Title

EW Authorizations

- Prior authorizations are different for EW services – providers should speak to a member's care coordinator before they begin or change any EW services
- If an authorization is required, Care Coordinators need to submit a request to Medica for the claim to pay
- Medica's Utilization Management team does not answer questions regarding these types of services – these should be addressed to the Care Coordinators
- There is a list on Medica.com of which Elderly Waiver codes require a prior authorization available here.
- If no authorization is obtained, claims will deny
- If providers have questions on what is authorized, they can call the Provider Service Center to obtain this information

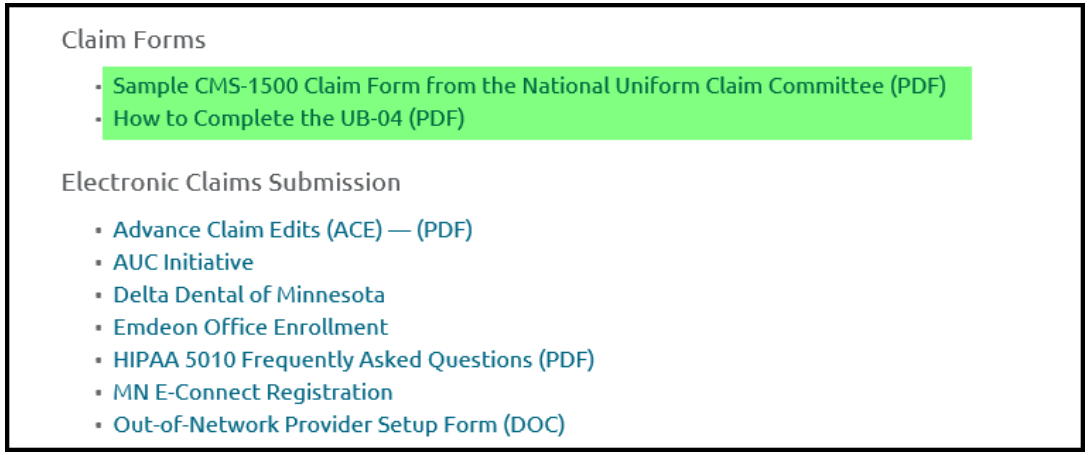
Claim Submission Process

Claim Submission Process

- MN providers are required to submit all claims electronically:
  - Electronic claims are accepted through various vendor systems (clearinghouses)
  - If you are having difficulty getting claims to Medica, you should first reach out to your clearinghouse
- Claims Submission
  - For all Medica members that EW providers would see, claims should be sent to:
    - Medica, PO Box 30990, Salt Lake City Utah, 84130-0990; Electronic Payer ID: 94265
- Claims need to be filled out following Minnesota Administrative Uniformity Committee (AUC) Guidelines – the AUC website is available here

Claim Submission Process

- There are two different types of claims:
  - Physician claims are submitted on a CMS-1500 claim form
  - Facility claims are submitted on a UB-04 claim form
- There are sample claim forms available on Medica.com, here, or at Medica.com>For Providers>Administrative Resources>Claims Tools



Claim Submission Process

- Once a claim is submitted to Medica, it is either accepted or rejected
- A rejected claim does not count as a claim submission – a letter will be sent explaining the reason of the rejection
- Medica does not keep rejected claims on file, although in some instances an image may be taken of the claim
- If a claim is rejected due to missing/incorrect information, you must correct the information and resubmit the claim
- If a provider disputes that claim information is missing or incorrect, they can call the Provider Service Center to see if an image was taken of the claim
- If the PSC representative can verify that the information on the claim is correct, they have the claim resubmitted on the provider's behalf

Claim Submission Process

- Once a claim is accepted, it goes through various claim edits, or checkpoints to verify if it is correct, and determine how it should pay
- These claim edits are required by CMS and DHS and based on correct coding guidelines
- Medica uses coverage policies, reimbursement policies and utilization management policies to determine if and how a claim should pay. Those polices are available on Medica.com at Medica.com>For Providers>Policies and Guidelines, or by clicking here
- For authorized services, claims will pay per the instructions on the authorization
- Providers will receive a Provider Remittance Advise that explains how much we are paying on each claim line, as well as why a claim or a portion of a claim is denying
- If providers have questions on how a claim paid, they can reach out to the PSC

Claim Appeals and Adjustments

Claim Appeals and Adjustments

Appeals

- If a provider feels that a claim should be processed and paid as originally submitted, they would submit an appeal using the Adjustment and Appeal Form on Medica.com
- Providers should fill out this form, explaining why they feel a claim should be payable, and including supporting documentation to help illustrate their point
- Providers should only submit the documentation that applies, and indicate where in the documentation the pertinent information is located
- If an appeal is denied and a provider has new information or wants to present it in a different way, they can submit a second (final appeal)
- If a provider has questions about the status of an appeal, they should call the PSC

Adjustments

- When a payment has been made on a claim, but a change is necessary, the Claim Adjustment or Appeal Request Form should be completed
- Can be initiated internally within Medica or done at a provider's request
- There is a 12 month limit for adjustments on both rejected and adjudicated claims
  - For rejected claims, the clean claim must be resubmitted and received within 12 months of the date of the denial or rejection
  - For adjudicated claims, the request must be received within 12 months of the check date on the PRA
- If a request for more information is received, the corrected claim or additional information must be received within 60 days of the date on the letter from Medica

Adjustments

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.

Resources and Upcoming Trainings

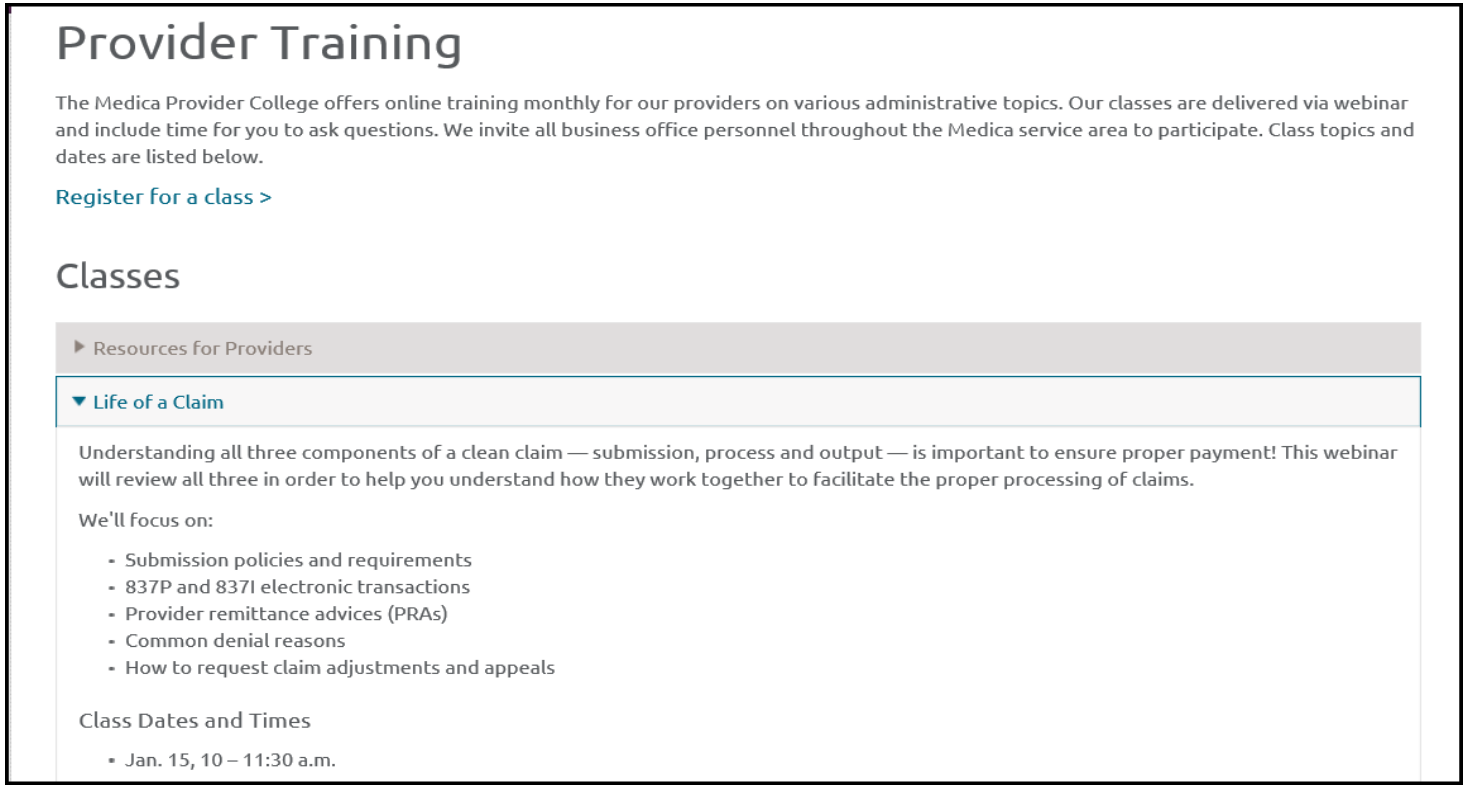
Medica has many resources to help providers who have questions

- Medica Provider Service Center
  - Providers can reach the Provider Service Call Center by calling 1-800-458-5512
  - Call Center hours:
    - Monday-Thursday 8:30 a.m. – 5:00 p.m.
    - Friday 9 a.m. – 5 p.m.
  - First point of contact for providers with eligibility, benefit, claim payment and claim process questions Resolve smaller claims issues
- Medica Provider College
  - For website issues or questions on where to locate resources, providers can email the Provider College at ProviderCollege@Medica.com

Resources and Upcoming Trainings

There is a page with a calendar of upcoming trainings on Medica.com

Medica.com>For Providers>Training or click here



Provider Training

The Medica Provider College offers online training monthly for our providers on various administrative topics. Our classes are delivered via webinar and include time for you to ask questions. We invite all business office personnel throughout the Medica service area to participate. Class topics and dates are listed below.

Register for a class >

Classes

▶ Resources for Providers

▼ Life of a Claim

Understanding all three components of a clean claim — submission, process and output — is important to ensure proper payment! This webinar will review all three in order to help you understand how they work together to facilitate the proper processing of claims.

We'll focus on:

- Submission policies and requirements
- 837P and 837I electronic transactions
- Provider remittance advices (PRAs)
- Common denial reasons
- How to request claim adjustments and appeals

Class Dates and Times

- Jan. 15, 10 – 11:30 a.m.

Any questions?

Thank You!

Questions? Email ProviderCollege@Medica.com

MEDICA®

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.