Sunshine Health- Multiple Claim Submission Wizard - LTC

Multiple Claims Submission

User Guide

Long Term Care Wizard

Secure Multiple Claims Submission Wizard

Secure Member Website

The Secure Provider Website has a Multiple Claim Submission claim wizard feature developed to allow Sunshine Health LTC providers to submit multiple recurring claims easily. The wizard saves time and reduces errors.

After creating a secure provider Sunshine Health website account, LTC providers can create member rosters based on the service location. Claims for Home Health Waivers, Adult Day Care, Personal Care Workers, Assisted Living Facilities, Bed Holds, Hospice, Nursing Facility Residential and SNF-Skilled Nursing Facilities can be repeated daily, weekly or monthly with only minimal coding required.

This user guide shows you how to submit claims using the Multiple Claim Submission Wizard and how to access its many features to better manage your health care billing.

Alert

- The layout of the screen may vary depending on your browser settings.

- Users of Internet Explorer 7.0 or prior may encounter problems. We highly recommend that you upgrade to Internet Explorer 8.0 or later. You can download the latest version of Internet Explorer at http://windows.microsoft.com/en-us/internet-explorer/download-ie.

Contents

Contents   This user guide is divided into the following sections:

Creating a Secure Provider Website

Create Account

To use the Multiple Submission Claim Wizard you must first create a Secure Provider Website account. Once you have an account, you can:

1. Check member eligibility
2. View or submit authorizations
3. View member health alerts
4. Submit or track your claims and get paid fast
5. Send and receive secure messages from Sunshine Health.

Please contact your Provider Relations Representative if you have any questions creating your account.

Who should Use the Multiple Claim Submission Wizard?

Who?   Multiple Claim Submission Wizard was designed to be used by Long Term Care Providers for billing the services listed below:
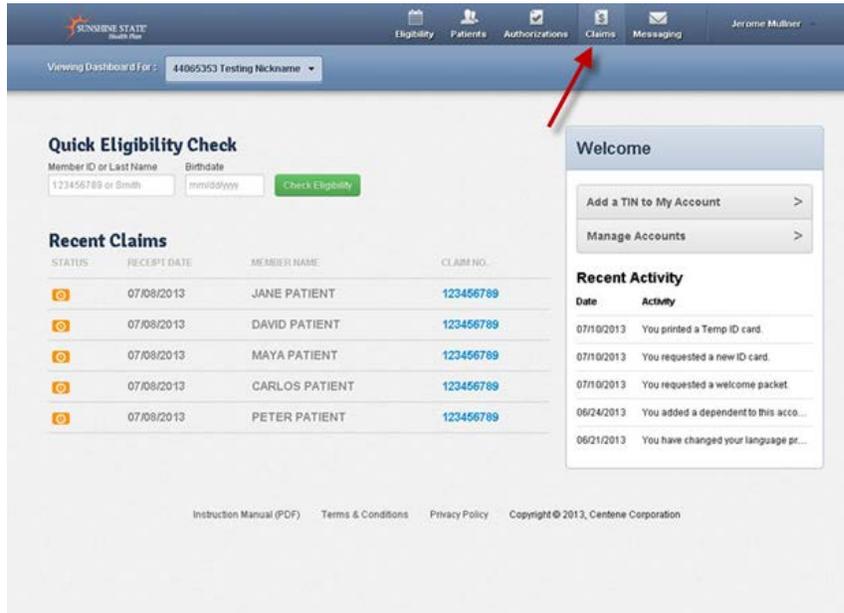
- Adult Day Care

- Home Health Waiver

- Personal Care Worker

- Assisted Living Facilities

- Home Meals

- Bed Hold

- Hospice

- Nursing Facility Residential
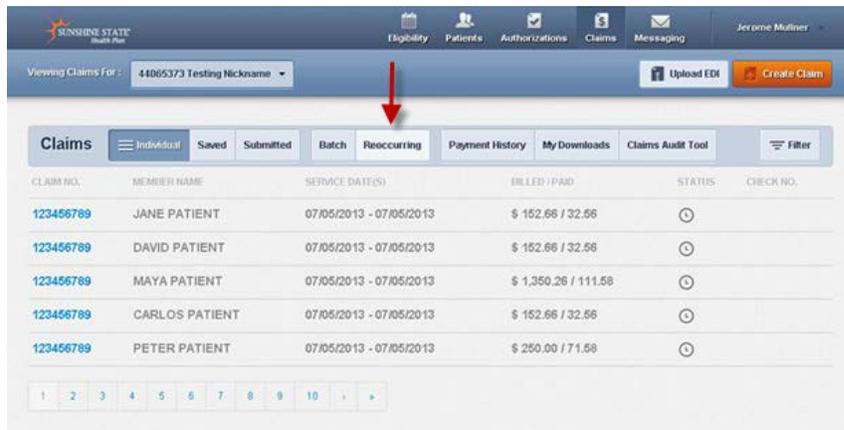
- SNF – Skilled Nursing Facility

Getting Started

Accessing the Wizard

To create LTC claims using the Multiple Claim Submission Wizard click on Claims tab.

Click on the Recurring Tab to access the Wizard.

Select Template (1500 HCFA)

Select a Template to Start Your Claim from the drop down. The example below uses a HCFA 1500 form.

The template is designed to speed up the claim submission process and contains pre-coded claim data. Refer to Appendix A for list of pre-coded items. You have the opportunity to change any of those items as needed prior to submitting the claim.

Service Location

Service Location

Select the desired <mark>service address</mark> from the dropdown.

Member List

View member List	Click on <mark>View Member List</mark>:

⚠️ Member lists are created using Member (Medicaid) ID or Last Name and Birthdate.   The member list only needs to be created once, during your first time using the Multiple LTC Wizard.

Add Member

Enter Member ID or Last Name and Birthdate. Member ID is the Medicaid ID on the member ID card. Click <mark>Add Member</mark>

You will see Member Added message. You can either enter another member or move on to create claim.

Under **Actions** click the X to remove the member from your member list. If a claim has already been submitted you can click on the page icon to view the last LTC claim submitted for that member.

Note: The member record is listed in alphabetic order by last name. If you are unable to locate member check member id and birthdate was entered correctly. If still not found return to Check Eligibility to verify member is eligible.

Create claim(s) by selecting the appropriate Member(s)

Create Claim (1500)

For each member selected enter the:

- Modifier (if applicable)
- First date of service (DOS Start)
- Last date of service (DOS End)
- Total Charges
- Number of Days or Units

After entering all the required information, click **Create Claim(s)**.
Click on X under Action to delete the claim.

Note: To save time if the DOS Start and DOS End are the same for all checked members enter the dates at bottom and click Update All DOS. The Modifier (if required), Total Charges, and Days/Units must be entered for each selected member.

Remember that DOS must be from first to first from the same month (if billing monthly) or the same day (if billing daily)

Example: ALF's or AFCH and some other providers: 09/01/2013 – 09/01/2013 to bill for 1 month, ADC; HDM indicating - 1 (day/unit/item) or HHA - 4 units.

Review claim

To review/edit or Add click on the action icon eye. You can review the claim or change some fields/add another line of service if applicable. Please closely review the Procedure Numbers and Modifiers that are about to be billed for accuracy. Some fields may not allow you to edit. If those fields need to be changed you will need to delete the claim and start over. If you need and it will allow Adding (Add) a Line, it can be Added for a Daily billing (see previous page for details) and then click Save. Refer to appendix for specific template coding. You can click on the X to delete claim.

Certify Claim(s)

Click Save and Close button once you've completed reviewing the claim.

Success!

After all the claims have been reviewed, select "V (check off) - I certify that these claims are accurate" and click Submit Claims.

Success! Your claims have been submitted!

Print submitted claims

Click on Print (on the bottom) to print a copy of the claims submitted including the Web Reference number.   Click Submit More Claims to return to the claims screen to request a new template or move on to other functions.

_____

Select Template (1450 UB)

Click $Claims and Select "Recurring". Select a Template to Start Your Claim from the drop down. The example below uses a UB 1450 form.

The template is designed to speed up the claim submission process and contains pre-coded claim data. Refer to Appendix A for list of pre-coded items. You will have the opportunity to change any of those items as needed prior to submitting the claim.

Service Location

_____

Select the desired service address from the dropdown.

Service Location

Member List

_____

Click on view member list.

View Member List
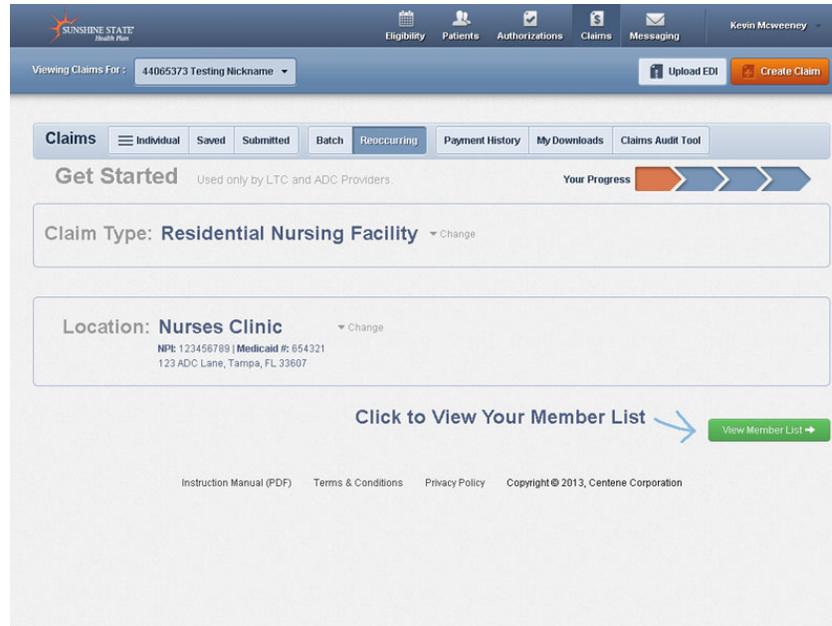
Member lists are created using Member (Medicaid) ID number and birthdate. The member list only needs to be created once during your first time using the Multiple Claims Submission Wizard.

Enter Member ID or Last Name and Birthdate. Member ID is the Medicaid ID on the member ID card. Click on Add Member.
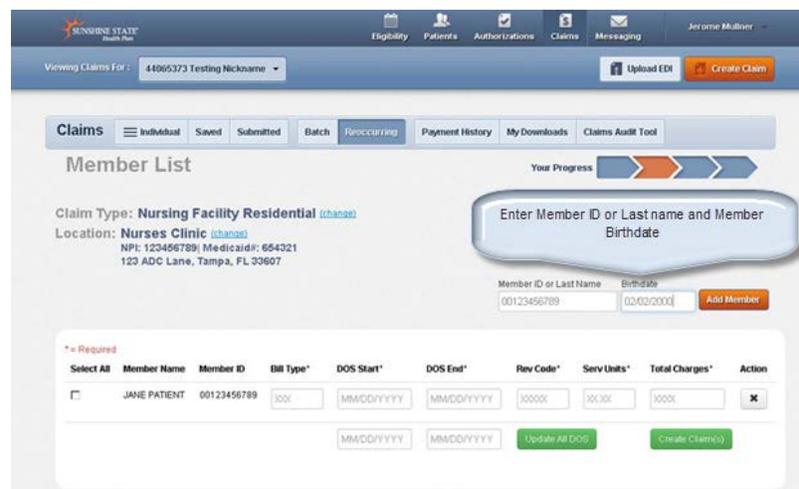
Add member

_____

You will see Member Added. You can either <mark>enter another member or move on to create claim</mark>. Under Actions click the X to remove a member from your list. If a claim has already been submitted you can click on the page icon to view the last LTC claim submitted for that member.

Remember! Members are listed in alphabetic order by last name.
If you are unable to locate a member check that the Member ID and birthdate was entered correctly. If the member record is still not found return to Check Eligibility to verify member is eligible.

Create a Claim(s)

Create claim(s) 1450 UB

_____

Create claim(s) by selecting the appropriate member(s) from Member List.

For each member selected enter the:

- Bill Type

- First date of service (DOS Start)

- Last date of service (DOS End)

- Rev Code (Revenue Code)

- Serv Units (days or service units)

- Total Charges

After entering all the required information, click Create Claim(s). Click on X under Action to delete the claim.

Note: To save time and the DOS Start and DOS End are the same for all checked members enter at bottom and click Update All DOS. The other fields must be entered for each selected member.

Review Claim
(Coming soon)

Certify the claims being submitted are accurate. You can review claims prior to submitting.

To review click on the eye. You can review the claim or change some of the fields pre-coded for you. Some fields may not allow you to edit. If those fields need to be changed you will need to delete the claim and start over. Refer to appendix for specific template coding. You can click on the X to delete claim.

Click the close button once you've finished reviewing the claim.

Certify Claim(s)

After all the claims have been reviewed for accuracy, select "I certify that these claims are accurate" and click Submit Claims.

Success!

Success! Your claims have been submitted!

Print submitted claims

Click Print to print a copy of the claims submitted including the web reference #. Click Submit More Claims to request a new template or move on to other functions.

Additional Notes

Help

If at any time you need help with the website, call your Provider Relations Representative or the Sunshine Health Provider Services Department at the toll-free number listed on the back of the member's ID card. A Provider Services Representative will be more than happy to assist you.

Checks will be sent to the financial address we have affiliated to the service location within our files unless you have Electronic Fund Transfer. If the financial address is incorrect, please contact your Provider Relations Representative.

Appendix A: Templates

Templates (HCFA 1500)

Pre-Coded Templates are provided to make using the Multiple Claims Submission Wizard easy for you to submit claims. Codes can be changed prior to claim submission if necessary.   Sunshine Health is closely aligned with AHCA and HIPPS standard edits.   Please contact your Provider Relations Specialist with any questions or concerns.

1500 Claims

Adult Day Care (Each day must be billed separately)

- Location code: 99
- Diagnosis code: 78099
- CPT/HCPCS: S5102 (Code cannot be billed with a date span)
- Days/Units: 1 unit per day

Home Health Waiver (Each day must be billed separately)

- Location code: 12
- Diagnosis code: V609
- CPT/HCPCS: T1004 (Code cannot be billed with a date span)
- Days/Units: 1 unit = 15 mins of care

Assisted Living Facilities *

- Location code: 13
- Diagnosis code: V609
- CPT/HCPCS: T2030 (Code cannot be billed with a date span)
- Days/Units: 1 unit = 1 month

Personal Care Workers

- Location code: 12
- Diagnosis code: V609
- CPT/HCPCS: S5125 (Code cannot be billed with a date span)
- Days/Units: 1 unit = 15 mins of care

Home Delivered Meals

- Location code: 12
- Diagnosis code: V609
- CPT/HCPCS: S5170 (Code cannot be billed with a date span)
- Days/Units: 1 unit = 1 day

Templates (UB - 04)

UB 1450 Claims

Bed Hold

- Type of Bill: 211
- Discharge status: 30
- Diagnosis code: V5789
- Revenue Code: 180
- Days/Units: 1 unit = 1 day

Nursing Facility Residential *

- Type of Bill: 211
- Discharge status: 30
- Diagnosis code: V5789
- Revenue Code: 101
- Days/Units: 1 unit = 1 day

Skilled Nursing Facility (SNF) *

- Type of Bill: 211
- Discharge status: 30
- Diagnosis code: V5789
- Revenue Code: 191
- Days/Units: 1 unit = 1 day

Hospice (Room and Board Only)

- Type of Bill: 813

- Discharge status: 30

- Diagnosis code: 79989

- Revenue Code: 658

- Days/Units: 1 unit = 1 day

*Recommended Billing frequency = Monthly

Appendix B: AHCA Guidelines

AHCA Guidelines

CODE	CODE DESCRIPTION	EDIT DESCRIPTION
T1004	SERVICES OF A QUALIFIED NURSING AIDE, UP TO 15 MINUTES	Code cannot be billed with a date span.
S5170	HOM DELIV MEALS INCL PREP;-MEAL	Code cannot be billed with a date span.
S5161	EMERG RESPONSE SYS; SRVC FEE-MONTH	Code cannot be billed with a date span.
S5130	HOMEMAKER SERVICE NOS; PER 15 MIN	Code cannot be billed with a date span.
T1005	RESPITE CARE SERVICES, UP TO 15 MINUTES	Code cannot be billed with a date span.
S5135	COMPANION CARE ADULT; PER 15 MIN	Code cannot be billed with a date span.
S5102	DAY CARE SERVICES, ADULT; PER DIEM	Code cannot be billed with a date span.
S5125	ATTENDANT CARE SERVICES; PER 15 MIN	Code cannot be billed with a date span.
S5165	HOME MODIFICATIONS; PER SERVICE	Code cannot be billed with a date span.
T2030	ASSISTED LIVING, WAIVER, PER MONTH	Code cannot be billed with a date span.

Appendix C: Type of Bill Codes

Type of Bill Codes

Type of bill codes are three digit codes located on a claim form that describes the type of bill a provider is submitting to a payer. Each digit has a specific purpose and is required on all UB-04 claims in field locator 4.

First Digit
The first digit refers to the type of facility. 1 - Hospital
2 - Skilled Nursing
3 - Home Health
4 - Religious Nonmedical Health Care Facility (Hospital)
5 - Religious Nonmedical Health Care Facility (Extended Care)
7 - Clinic
8 - Specialty Facility, Hospital ASC Surgery

Second Digit
The second digit refers to the bill classification except for clinics and special facilities.

If the first digit is numbers 1 - 5, then the second digit is:
1 - Inpatient
2 - Inpatient
3 - Outpatient
4 - Other
5 - Level I Intermediate Care
6 - Level II Intermediate Care
7 - Subacute Inpatient (for use with Revenue Code 019X)
8 - Swing Bed
The second digit refers to the bill classification for Special Facilities Only.

If the first digit is 8, then the second digit is:
1 - Nonhospital Based Hospice
2 - Hospital Based Hospice
3 - Ambulatory Surgical Center Services to Hospital Patients
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center (CMHC)

Third Digit
The third digit refers to the frequency.

0 - Nonpayment or Zero Claims
1 - Admit Through Discharge Claim
2 - Interim (First Claim)
3 - Interim (Continuing Claims)
4 - Interim (Last Claim)
5 - Late Charge Only
7 - Replacement of Prior Claim or Corrected Claim
8 - Void or Cancel of a Prior Claim
9 - Final Claim for a Home Health PPS Episode