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.
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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.

Secure Provider Website Registration

To create your secure website, follow these instructions:

1) Browse the public website to register. Under ‘For Providers’ click on ‘Login’.
2) Click on ‘Create an Account’. Registration is fast and simple.
3) Start your registration. Enter Tax ID, name, email address, and create your own password. Never over the ‘?’ for more details. Click ‘Register’.
   If you receive the error message ‘We could not find your Tax ID in our system’ please return to our public site ‘Become a Provider’ page to join the network. Once your data is in our systems you will be able to register.
4) Registration complete! An email will be sent to your mailbox. Click the link in the email to sign in and finish setting up your account.
   If you do not receive your email, check your junk file or click the ‘click here’ hyperlink on the registration confirmation page to have another email sent to you.
5) Now that you’ve signed into the site, select your secret questions and answers. You will use these if you forget your password or accidentally lock your account. Enter your telephone and fax number. Click ‘Submit’.
6) Your request for an account has now been sent to the Health Plan for approval. If you do not receive an email within 2 work days, please call the plan or send a secure message.
7) Once approved you will receive an email and you can begin enjoying the site.

** System requirements: Access the secure provider website using Internet Explorer 8.0 or higher, Firefox and/or Google Chrome. Each browser should be updated to the most recent version available for optimal performance.

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 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

Select the desired service address from the dropdown.
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 Add Member

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)

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.
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 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.
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.
Select the desired service address from the dropdown.
Click on 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.
You will see Member Added. You can either enter another member or move on to create claim. 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.

![Member List]

**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) 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.
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!
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

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

<table>
<thead>
<tr>
<th>CODE</th>
<th>CODE DESCRIPTION</th>
<th>EDIT DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1004</td>
<td>SERVICES OF A QUALIFIED NURSING AIDE, UP TO 15 MINUTES</td>
<td>Code cannot be billed with a date span.</td>
</tr>
<tr>
<td>SS170</td>
<td>HOM DEUV MEALS INCL PREP; MEAL</td>
<td>Code cannot be billed with a date span.</td>
</tr>
<tr>
<td>SS161</td>
<td>EMERG RESPONSE SYS; SRVC FEE MONTH</td>
<td>Code cannot be billed with a date span.</td>
</tr>
<tr>
<td>SS130</td>
<td>HOMEMAKER SERVICE NOS; PER 15 MIN</td>
<td>Code cannot be billed with a date span.</td>
</tr>
<tr>
<td>T1005</td>
<td>RESPITE CARE SERVICES, UP TO 15 MINUTES</td>
<td>Code cannot be billed with a date span.</td>
</tr>
<tr>
<td>SS135</td>
<td>COMPANION CARE ADULT; PER 15 MIN</td>
<td>Code cannot be billed with a date span.</td>
</tr>
<tr>
<td>SS102</td>
<td>DAY CARE SERVICES, ADULT; PER DIEM</td>
<td>Code cannot be billed with a date span.</td>
</tr>
<tr>
<td>SS125</td>
<td>ATTENDANT CARE SERVICES, PER 15 MIN</td>
<td>Code cannot be billed with a date span.</td>
</tr>
<tr>
<td>SS165</td>
<td>HOME MODIFICATIONS; PER SERVICE</td>
<td>Code cannot be billed with a date span.</td>
</tr>
<tr>
<td>T2030</td>
<td>ASSISTED LIVING, WAIVER, PER MONTH</td>
<td>Code cannot be billed with a date span.</td>
</tr>
</tbody>
</table>
Appendix C: Type of Bill Codes

<table>
<thead>
<tr>
<th>Type of Bill Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Digit</strong></td>
<td>The first digit refers to the type of facility.</td>
</tr>
<tr>
<td>1 - Hospital</td>
<td>Inpatient</td>
</tr>
<tr>
<td>2 - Skilled Nursing</td>
<td>Inpatient</td>
</tr>
<tr>
<td>3 - Home Health</td>
<td>Outpatient</td>
</tr>
<tr>
<td>4 - Religious Nonmedical Health Care Facility (Hospital)</td>
<td>Other</td>
</tr>
<tr>
<td>5 - Religious Nonmedical Health Care Facility (Extended Care)</td>
<td>Level I Intermediate Care</td>
</tr>
<tr>
<td>7 - Clinic</td>
<td>Level II Intermediate Care</td>
</tr>
<tr>
<td>8 - Specialty Facility, Hospital ASC Surgery</td>
<td>Subacute Inpatient (for use with Revenue Code 019X)</td>
</tr>
<tr>
<td></td>
<td>Swing Bed</td>
</tr>
<tr>
<td><strong>Second Digit</strong></td>
<td>The second digit refers to the bill classification except for clinics and special facilities.</td>
</tr>
<tr>
<td></td>
<td>If the first digit is numbers 1 - 5, then the second digit is:</td>
</tr>
<tr>
<td>1 - Inpatient</td>
<td>Admit Through Discharge Claim</td>
</tr>
<tr>
<td>2 - Inpatient</td>
<td>Interim (First Claim)</td>
</tr>
<tr>
<td>3 - Outpatient</td>
<td>Interim (Continuing Claims)</td>
</tr>
<tr>
<td>4 - Other</td>
<td>Interim (Last Claim)</td>
</tr>
<tr>
<td>5 - Level I Intermediate Care</td>
<td>Late Charge Only</td>
</tr>
<tr>
<td>6 - Level II Intermediate Care</td>
<td>Replacement of Prior Claim or Corrected Claim</td>
</tr>
<tr>
<td>7 - Subacute Inpatient (for use with Revenue Code 019X)</td>
<td>Void or Cancel of a Prior Claim</td>
</tr>
<tr>
<td>8 - Swing Bed</td>
<td>Final Claim for a Home Health PPS Episode</td>
</tr>
<tr>
<td><strong>Third Digit</strong></td>
<td>The third digit refers to the frequency.</td>
</tr>
<tr>
<td>0 - Nonpayment or Zero Claims</td>
<td></td>
</tr>
<tr>
<td>1 - Admit Through Discharge Claim</td>
<td></td>
</tr>
<tr>
<td>2 - Interim (First Claim)</td>
<td></td>
</tr>
<tr>
<td>3 - Interim (Continuing Claims)</td>
<td></td>
</tr>
<tr>
<td>4 - Interim (Last Claim)</td>
<td></td>
</tr>
<tr>
<td>5 - Late Charge Only</td>
<td></td>
</tr>
<tr>
<td>7 - Replacement of Prior Claim or Corrected Claim</td>
<td></td>
</tr>
<tr>
<td>8 - Void or Cancel of a Prior Claim</td>
<td></td>
</tr>
<tr>
<td>9 - Final Claim for a Home Health PPS Episode</td>
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</tr>
</tbody>
</table>