



Viewing Nursing Home Authorizations on the Inclusa Provider Portal:

The **Minimum Data Set (MDS)** is part of a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. The MDS determines the HIPPS/PDPM score for the member, which determines the rate.

When Inclusa Authorization & Claims Support (ACS) receives a referral from Inclusa Care Managers that an authorization is to be entered for a nursing home stay with Inclusa as Primary Payer, an authorization will initially be entered with a default rate of .01.

When the facility views their authorizations on the portal and sees an authorization with .01 authorized, they **need** to report the HIPPS level via the process stated below so that a new authorization can be created. If a HIPPS level is not provided and the provider bills for the stay using the default auth, they will only be paid at a rate of .01 per day. If the member is enrolled in Hospice services, please communicate that as the facility specific Hospice rate will be authorized vs a HIPPS score rate.

The default auth created by Inclusa will include the following note and guidance:

DEFAULT AUTH – PLEASE PROVIDE HIPPS SCORE

This authorization serves as a placeholder until a HIPPS Score with effective dates are received for this member. Please do not bill on this authorization as it will only pay out \$0.01.

Please complete the Member Notification Form to report the member’s HIPPS score(s) and effective date, located here:

https://www.inclusa.org/wp-content/uploads/Member-Notification-Form_Nursing-Home.docx

Forms can be emailed to: absenceandchangereporting@inclusa.org OR faxed to 866-880-0551

Upon receipt of the notification, a new authorization will be entered with the HIPPS rate. Please continue to report HIPPS changes throughout the course of the member’s stay utilizing this form.

If at any point this member’s coverage changes (Medicare/Hospice, etc.), or the member has an absence, please complete the Member Notification Form to report these changes so your authorizations can be adjusted accordingly. Thank you.

Reporting HIPPS Levels to Inclusa:

When a new placement starts or a HIPPS level changes, the nursing home facility needs to send the information to Inclusa so that the authorization can be updated. At minimum, they need to send the following information:

- Member Name
- HIPPS level
- Effective date of HIPPS level – level will be entered as of the effective date

Note: Per Appendix F of your contract: “Provider will provide Purchaser the individual HIPPS scores for Inclusa Inc. members each time a new MDS is completed by Provider within fifteen (15) days of completion.”

If Medicare is funding the member’s stay or the member is enrolled in Hospice, a HIPPS score does not need to be reported.



Provider Nursing Home Authorization Information

Nursing home providers can report HIPPS scores via completion of the *Member Notification Form – Nursing Home* which can be found on the Inclusa website: [https://www.inclusa.org/wp-content/uploads/Member Notification Form Nursing Home.pdf](https://www.inclusa.org/wp-content/uploads/Member_Notification_Form_Nursing_Home.pdf)

This form can be emailed to absenceandchangereporting@inclusa.org or faxed to 866-880-0551.

This form can also be submitted online at this link:

<https://www.cognitofrms.com/Inclusa1/NursingHomeMemberNotificationForm>

If the nursing home needs to report a change for more than one member at the same time, the information can be sent via one email to: absenceandchangereporting@inclusa.org or faxed to 866-880-0551, providing the information as stated above. When using the Notification form, please complete one form per member.

If submitting the Minimum Data Set (MDS) report, ONLY section Z needs to be sent to: absenceandchangereporting@inclusa.org or faxed to 866-880-0551. If section Z is used to report a HIPPS score, note that unless otherwise indicated, we will assume that the date on Section Z is the effective date of the HIPPS score indicated.

Note that *Member Notification Form – Nursing Home* must also be used to report when a member enrolls in hospice care, disenrolls from hospice care, begins or ends a Medicare Covered stay, and when the member is absent from the nursing home. These changes should be reported within 24 business hours.

A signature is only required on the Notification form if the provider is requesting a bed hold due to a member absence. A bed hold can be requested if your facility is at 94% occupancy at the time of the absence, the Leave of Absence service code is on your contract, and there is an intention for the member to return to your facility after the absence. If requesting a Bed hold, please check the box titled “Bed Hold Request”. By checking this box and signing the form, you are certifying that your facility is at 94% occupancy. A bed hold cannot be authorized if occupancy requirements are not met. If approved, a Bed hold/Leave of Absence authorization can be authorized for up to 15 days.

Claim Submission requirements for HIPPS score billing under Revenue Code 0022

Claims submitted with revenue code 0022 **on or after 5/1/2024, regardless of date of service on the claim,** must include the members HIPPS code. The full 5- character code should be indicated in the designated field, which would include 4 letters followed by one number as per the member’s MDS assessment. **Example HIPPS CODE:** KAKE6

If billing the Default HIPPS rate due to no MDS completion required, please indicate **ZZZZZ** on the claim.

Corrected Claim forms will also now require the inclusion of the HIPPS codes when correcting a previously paid 0022 HIPPS claim.

If the HIPPS score is not identified on the claim, the claim will deny. In the event of a claim denial, please resubmit the claim within the 120-day Timely Filing limit and include the HIPPS score.

Skilled Nursing Facilities located in Minnesota are exempt from noting a HIPPS score on your 0022 claims.



Provider Nursing Home Authorization Information

Please refer to table below outlining the designated location on each claim type where the HIPPS code must be indicated.

Appropriate placement of HIPPS codes for each WPS submission method:

Non-standard paper claim

Box 18: HCPCS/CPT/HIPPS

UB-04

Box 44: HCPCS/RATE/HIPPS CODE

Corrected Claim Form

CPT/HCPCS/REV/HIPPS

Spreadsheet Claims

HCPCS/CPT (Service Code) HIPPS Code

837i

Loop 2400 SV202-1 with HP qualifier

PC-ACE

Billing Line Items tab: Box 44 CPT HCPCS

Ext Details (Line X) tab: Procedure type = HP



Medicare Co-Insurance Stays

When Inclusa Authorization & Claims Support (ACS) receives a referral from Inclusa Care Managers that an authorization is to be entered for a nursing home stay with Medicare as Primary Payer, an authorization will be entered with a default rate of .01 for 100 days. If at some point during the 100 days Medicare co-insurance coverage ends, the nursing home facility needs to inform Inclusa of the last Medicare co-insurance covered date and the date that Inclusa would start funding, along with the HIPPS level.

Medicare Co-insurance authorizations issued by Inclusa will also include the following note in effort to provide guidance regarding Coinsurance claims:

MEDICARE COINSURANCE

This authorization reflects that this member's stay is being covered by Medicare. Please do not bill on this authorization. Medicare A claims will automatically crossover to WPS for processing of the Coinsurance payment as per COBA process Claims for members who have Medicare C or Private Insurance must be sent directly to WPS along with the EOB(s). This authorization # should be indicated on your claim. Claims must be submitted within 120 days of the date on the primary payor's EOB. If this member's stay is not being covered by Medicare or Private insurance OR coverage has ended, please complete the Member Notification Form to report the member's HIPPS score(s) and effective date, located here: https://www.inclusa.org/wp-content/uploads/Member-Notification-Form_Nursing-Home.docx

Forms can be emailed to: absenceandchangereporting@inclusa.org or faxed to 866-880-0551.

HIPPS Rate Updates/Retro Rate Changes

On a monthly basis, Inclusa monitors for updated Rate Spreadsheets on the Meyers and Stauffer website. <https://myersandstauffer.com/client-portal/wisconsin/#toggle-id-1>

Within 90 days of the rates posting date, Inclusa will automatically:



Provider Nursing Home Authorization Information

- End current authorizations will end based on the last date of service paid.
- New authorization will be entered at the new rate.
- If rates increased, additional due authorizations will be issued for the difference owed.
- If rates decreased, Inclusa will initiate refunds. Information regarding the refund process can be found here: <https://www.inclusa.org/providers/claims-billing/provider-refund-request-for-wps-2/>
- **NOTE:** MCO's are required to process both Interim and Final Rates. Inclusa will follow the same process listed above when actioning differences between interim and final rates.

Providers are no longer required to make formal requests or submit a *Retro Spreadsheet* to receive the additional funds for these specific types of retro rate changes.

The "RETRO RATE ADJUSTMENT–ADDITIONAL DUE" authorization will be entered based on the difference between the rate that Inclusa initially authorized and the new rate posted by DHS for the HIPPS score you previously provided to Inclusa for the dates of service in question. The retro additional due authorization will not account for any short billing that occurred related to providers billing less than the authorized rate(s) made available to you. If you have identified that you billed less than the authorized rate, please complete a Corrected Claim form within the 120-day timely filing parameter. The corrected claim form can be found here: <https://www.wpshealth.com/resources/files/famc-corrected-claim-form.pdf>

The HIPPS score you previously reported will be indicated in the notes section of your "RETRO RATE ADJUSTMENT–ADDITIONAL DUE" authorization. If that HIPPS score is not accurate please report the correct HIPPS score and effective date via Inclusa's Member Notification form located here: https://www.inclusa.org/wp-content/uploads/Member-Notification-Form_Nursing-Home.docx to allow for accurate authorization adjustments.

Providers will need to confirm these newly created authorizations on the Inclusa Provider Portal found here: <https://providerportal.inclusa.org>, prior to submitting claims (login required).

Providers will submit **new** claim(s) using the "RETRO RATE ADJUSTMENT–ADDITIONAL DUE" authorization number, directly to Wisconsin Physicians Service (WPS), our third-party administrator. Providers should not use the Corrected Claim form when billing new claims on the additional due authorization. The dates of service submitted on the claim for the RETRO RATE ADJUSTMENT–ADDITIONAL DUE authorization should match the dates of service billed on the previous HIPPS authorization(s) related to the service.

All other non-Retro Nursing Home claims continue to be subject to timely filing parameters (10 days from date of service)

Please note, when Inclusa is primary payor, Nursing home Providers can utilize the "Move It" spreadsheet to submit claims electronically. The spreadsheet claim option will allow you to submit claims for all members at the same location on the same claim spreadsheet VS completing a UB04 for each individual member. If interested in registering to submit spreadsheet claims, please outreach to: FCWPS@wpsic.com



Provider Nursing Home Authorization Information

In order to ensure accuracy within this process, we ask that you continue to report any member-specific pay source changes, absences, and HIPPS score changes in real time with an applicable effective date identified to ensure that your authorizations and subsequent claims are accurate. We encourage providers to utilize the Member Notification form when reporting these changes, as the form will guide you through the required information.

<https://www.cognitofrms.com/Inclusa1/NursingHomeMemberNotificationForm>

Please note that the above rate change/retro process also applies to authorizations related to Hospice, Leave of Absence, DD in house Rates, Commission Fees, Brain Injury, and Ventilator rates, etc. Inclusa monitors for rate changes monthly for Commission Fees, Brain Injury, and Vent rates at the following websites:

<https://www.dhs.wisconsin.gov/familycare/mcos/nh-rates.htm>

<https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Public/NursingHomeRateSchedule.aspx>

Questions?

- For questions about HIPPS/PDPM, please refer to your contact at the Wisconsin Department of Health Services (DHS).
- For questions related to your contract or services, contact Inclusa Provider Relations at ProviderRelations@inclusa.org or 877-622-6700 (select option 2, then option 3).
- For questions about Nursing Home authorizations or billing, contact the Inclusa Authorization & Claims support team at ACS-Residential-CSL-NH@inclusa.org or 888-544-9353 (select option 6).

Thank you for your ongoing partnership and support of Inclusa members!