Residential Respite Claim Submission Tips For Residential Providers

Prior Authorization

- All Inclusa funded services must be prior authorized by the member's Care Managers.
- Respite services must be on your contract in order for them to be authorized and funded by Inclusa.

Timeframe Limitations

- If respite is authorized, the following limitations apply:
  - 1-2 bed certified AFHs can provide 28 consecutive days of respite for a member and no more than 90 days of respite total in a calendar year.
  - 3-4 bed licensed AFHs can provide no more than 14 consecutive days of respite for a member.
  - A CBRF can provide no more than 28 consecutive days of respite for a member.

Billing Differences between Respite Services and Residential Single Daily rate

(Single daily rate includes Care & Supervision and Room and board)

- Respite claims are considered "Professional" vs "Institutional"
  - This is especially important to note, when using Move it Spreadsheet or PC-ACE for claims submissions.

- Respite services are billed with a HCPCS code VS a 4-digit Revenue code. A HCPCS code is a 5-character alpha numeric code that starts with a letter and ends with 4 numbers. Some HCPCS codes are also followed by a Modifier Code. The code and modifier (if applicable) are indicated on your authorization.

  - The most common HCPCS code & Modifier used for Residential for respite is: ***S9125 UA***. 1 unit = 1 day.
  - **As shown on authorization:**

    Procedure/Service Code: S9125
    Modifier 1: UA
    Modifier 4:

  - Some Residential providers may have code T1005. I unit = 15 minutes. This HCPCS code does not have a modifier.
  - **As shown on authorization:**

    Procedure/Service Code: T1005
    Modifier 4:

Claim Submission via Paper Claim Form (Form can be used by any provider at any time)

When using the paper claim, use one claim form per member. Cannot submit claims for multiple members on the same paper claim form.

- **Example #1 – Clean Correct Claim:** Screenshot below shows a claim for 1 day of respite under code S9125 UA. 1 day = 1 unit under code S9125 UA. This claim is completed correctly.

INCLUSA CLAIM FORM

WPS HEALTH INSURANCE

MEMBER INFORMATION

1. Member Identification #:	123456789	4. Member Date of Birth:	01/01/1900
2. Member Last Name:	Member	5. Member First Name:	Name
3. Primary Diagnosis Code (Optional):		6. Patient Account (invoice) #:	

PROVIDER SERVICING ADDRESS (SERVICING PROVIDER'S BUSINESS ADDRESS)		PROVIDER BILLING ADDRESS (PHYSICIAN'S OR SUPPLIER'S BILLING ADDRESS)	
7. Provider TAX/EIN/SSN:	999999999	11. Provider Billing NPI #:	
8. Business Name:	Provider A	12. Billing Provider Name:	Provider A
9. Business Address:	Provider Address A	13. Billing Address:	Provider Address A
10. City/State/Zip Code:	City, State, Zip Code A	14. City/State/Zip Code:	City, State, Zip code A

15. Date of Service (MM/DD/YY) (Date Span or Individual Days)		16. Type of Bill	Service Code		19. Modifiers				20. Authorization Number	21. Rendering Provider NPI #	22. Units Billed	23. ($) Total Charge
From Date	To Date		17. Revenue Code	18. HCPCS/ CPT	1	2	3	4				
11/01/22	11/01/22			S9125	UA				100009999999		1	100.00

26. Disclaimer Code:	I certify that all services indicated above have been provided. (Claims for services must reflect actual services provided.)			24. ($) Total Charges:
	25. Authorized Signature: Provider A	Print Name: Provider A	Date: 11/21/2022	100.00

Claim Reminders:
*One member per claim form
*One authorization number per claim line
*Use same service code that is listed on the Inclusa Service Authorization form

Claim Status Questions:
WPS Family Care Contact Center:
800-223-6016

Please Mail this Claim Form to:
Family Care
c/o WPS Health Insurance
P.O. Box 211595
Eagan, MN 55121
or
FAX: 608-327-6332 (Do NOT include coversheet)

- **<u>Example #2: Clean Correct Claim</u>**: Screenshot below shows a claim for 1 hour of respite under code T1005. 1 unit of T1005 = 15 minutes, therefore 4 units are billed for 1 hour of respite. This claim is completed correctly.

INCLUSA CLAIM FORM

WPS HEALTH INSURANCE

MEMBER INFORMATION

1. **Member Identification #:**	123456789	4. **Member Date of Birth:**	01/01/1900
2. **Member Last Name:**	Member	5. **Member First Name:**	Name
3. **Primary Diagnosis Code (Optional):**		6. **Patient Account (invoice) #:**	
PROVIDER SERVICING ADDRESS *(SERVICING PROVIDER'S BUSINESS ADDRESS)*		**PROVIDER BILLING ADDRESS** *(PHYSICIAN'S OR SUPPLIER'S BILLING ADDRESS)*	
7. **Provider TAX/EIN/SSN:**		11. **Provider Billing NPI #:**	
8. **Business Name:**	Provider A	12. **Billing Provider Name:**	Provider A
9. **Business Address:**	Provider Address A	13. **Billing Address:**	Provider Address A
10. **City/State/Zip Code:**	City, State, Zip A	14. **City/State/Zip Code:**	City, State, Zip A

15. **Date of Service** (MM/DD/YY) *(Date Span or Individual Days)* From Date	To Date	16. **Type of Bill**	**Service Code** 17. **Revenue Code**	18. **HCPCS/ CPT**	19. **Modifiers** 1	2	3	4	20. **Authorization Number**	21. **Rendering Provider NPI #**	22. **Units Billed**	23. **($) Total Charge**
11/01/22	11/01/22			T1005					100009999999		4	20.00

26. **Disclaimer Code:**

I certify that all services indicated above have been provided. (Claims for services must reflect actual services provided.)

25. **Authorized Signature:** Provider A **Print Name:** Provider A **Date:** 12/01/2022

24. **($) Total Charges:** 20.00

Claim Reminders:
*One member per claim form
*One authorization number per claim line
*Use same service code that is listed on the Inclusa Service Authorization form

Claim Status Questions:
WPS Family Care Contact Center:
800-223-6016

Please Mail this Claim Form to:
Family Care
c/o WPS Health Insurance
P.O. Box 211595
Eagan, MN 55121
or
FAX: 608-327-6332 (Do NOT include coversheet)

- **Example #3 – Incorrect Claim:** Screenshot below shows claims for both respite and single daily rate. The member entered the facility on 11/1 under respite. Their Respite stay ended on 11/28. The member's placement transitioned to a long-term placement on 11/29 which is authorized as a single daily rate with a revenue code. The provider is trying to bill all services for November.

  If the claim is submitted like this, one of the claim lines will be denied. On a paper claim, you cannot have claim lines with revenue codes and claim lines with HCPCS codes on the same form. You will need to submit two separate claim forms, one with the revenue code claim and one with the HCPCS code claim.

INCLUSA CLAIM FORM

WPS HEALTH INSURANCE

MEMBER INFORMATION

1. **Member Identification #:**	123456789	4. **Member Date of Birth:**	01/01/1900
2. **Member Last Name:**	Member	5. **Member First Name:**	Name
3. **Primary Diagnosis Code (Optional):**		6. **Patient Account (invoice) #:**	

PROVIDER SERVICING ADDRESS *(SERVICING PROVIDER'S BUSINESS ADDRESS)*		**PROVIDER BILLING ADDRESS** *(PHYSICIAN'S OR SUPPLIER'S BILLING ADDRESS)*	
7. **Provider TAX/EIN/SSN:**		11. **Provider Billing NPI #:**	
8. **Business Name:**	Provider A	12. **Billing Provider Name:**	Provider A
9. **Business Address:**	Provider Address A	13. **Billing Address:**	Provider Address A
10. **City/State/Zip Code:**	City, State, Zip A	14. **City/State/Zip Code:**	City, State, Zip, A

15. **Date of Service** (MM/DD/YY) *(Date Span or Individual Days)*		16. **Type of Bill**	**Service Code**		19. **Modifiers**				20. **Authorization Number**	21. **Rendering Provider NPI #**	22. **Units Billed**	23. **($) Total Charge**
From Date	**To Date**		17. **Revenue Code**	18. **HCPCS/ CPT**	**1**	**2**	**3**	**4**				
11/01/22	11/28/22			S9125	UA				100009999999		28	2,800.00
11/29/22	11/30/22		0243						100008888888		2	200.00

26. **Disclaimer Code:**

I certify that all services indicated above have been provided. (Claims for services must reflect actual services provided.)

25. **Authorized Signature:** Provider A **Print Name:** Provider A **Date:** 12/01/2022

24. **($) Total Charges:** 3000.00

Claim Reminders:
*One member per claim form
*One authorization number per claim line
*Use same service code that is listed on the Inclusa Service Authorization form

Claim Status Questions:
WPS Family Care Contact Center:
800-223-6016

Please Mail this Claim Form to:
Family Care
c/o WPS Health Insurance
P.O. Box 211595
Eagan, MN 55121
or
FAX: 608-327-6332 (Do NOT include coversheet)

Claim Submission via Move It Spreadsheet (Provider must be registered with EDI to use Move it)

Providers can include multiple members on the same spreadsheet claim.

Unlike the Paper Claim Form, providers CAN also include claims with revenue codes and claims with HCPCS codes on the same spreadsheet and WPS will process them.

- **Example #1 – Clean Correct Claim:** Screenshot below shows a claim for 1 day of respite under code S9125 UA. 1 day = 1 unit under code S9125 UA. This claim is completed correctly.

PROVIDER INFORMATION:					
Provider TAX ID/EIN/SSN:	999999999	Location # (reserved for WPS):		Group Name or Program Name:	MCO Name
Provider Billing NPI #:		Pend (reserved for WPS):		Provider Contact Name:	Biller Name
Servicing or Business Provider Name:	Provider A	Billing or Pay-to Provider Name:	Provider A	Provider Contact Email:	Biller Email
Servicing or Business Provider Address:	Provider Address A	Billing or Pay-to Provider Address:	ProviderAddress A	Provider Contact Phone:	Biller Phone
City:	City	City:	City		
State:	State	State:	State	Open Text:	
Zip Code:	Zip Code	Zip Code:	Zip Code		

CLAIM DETAIL INFORMATION:

Member Information						Date(s) of Service		UB-04 Institutional		HCFA Professional			Modifier						
Member ID #	First Name	Last Name	Middle Name or Initial	Date of Birth (MMDDCCYY)	Authorization #	Start Date (MMDDCCYY)	End Date (MMDDCCYY)	Type of Bill	Revenue Code (Service Code)	Place of Service	HCPCS/CPT (Service Code)	Primary Diagnosis Code	1	2	3	4	Disclaimer Codes (optional)	Total Units	Total Charges ($)
123456789	Member	Name	A	01011990	100009999999	11012022	11012022				S9125		UA					1	$ 100.00

- **Example #2: Clean Correct Claim:** Screenshot below shows a claim for 1 hour of respite under code T1005. 1 unit of T1005 = 15 minutes, therefore 4 units are billed for 1 hour of respite. This claim is completed correctly.

PROVIDER INFORMATION:					
Provider TAX ID/EIN/SSN:	999999999	Location # (reserved for WPS):		Group Name or Program Name:	MCO Name
Provider Billing NPI #:		Pend (reserved for WPS):		Provider Contact Name:	Biller Name
Servicing or Business Provider Name:	Provider A	Billing or Pay-to Provider Name:	Provider A	Provider Contact Email:	Biller Email
Servicing or Business Provider Address:	Provider Address A	Billing or Pay-to Provider Address:	ProviderAddress A	Provider Contact Phone:	Biller Phone
City:	City	City:	City		
State:	State	State:	State	Open Text:	
Zip Code:	Zip Code	Zip Code:	Zip Code		

CLAIM DETAIL INFORMATION:

Member Information						Date(s) of Service		UB-04 Institutional		HCFA Professional			Modifier						
Member ID #	First Name	Last Name	Middle Name or Initial	Date of Birth (MMDDCCYY)	Authorization #	Start Date (MMDDCCYY)	End Date (MMDDCCYY)	Type of Bill	Revenue Code (Service Code)	Place of Service	HCPCS/CPT (Service Code)	Primary Diagnosis Code	1	2	3	4	Disclaimer Codes (optional)	Total Units	Total Charges ($)
123456789	Member	Name	A	01011990	100009999999	11012022	11012022				T1005							4	100.00

- **Example #3 – Clean Correct Claim:** Screenshot below shows claims for both respite and single daily rate. The member entered the facility on 11/1 under respite. Their Respite stay ended on 11/28. The member's placement transitioned to a long-term placement on 11/29 which is authorized as a single daily rate with a revenue code. The provider is trying to bill all services for November.

PROVIDER INFORMATION:					
Provider TAX ID/EIN/SSN:	999999999	Location # (reserved for WPS):		Group Name or Program Name:	MCO Name
Provider Billing NPI #:		Pend (reserved for WPS):		Provider Contact Name:	Biller Name
Servicing or Business Provider Name:	Provider A	Billing or Pay-to Provider Name:	Provider A	Provider Contact Email:	Biller Email
Servicing or Business Provider Address:	Provider Address A	Billing or Pay-to Provider Address:	ProviderAddress A	Provider Contact Phone:	Biller Phone
City:	City	City:	City		
State:	State	State:	State	Open Text:	
Zip Code:	Zip Code	Zip Code:	Zip Code		

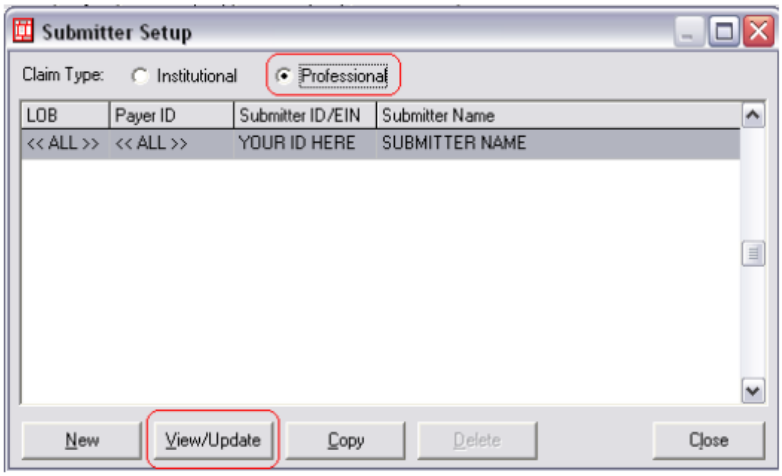
CLAIM DETAIL INFORMATION:

Member Information						Date(s) of Service		UB-04 Institutional		HCFA Professional			Modifier						
Member ID #	First Name	Last Name	Middle Name or Initial	Date of Birth (MMDDCCYY)	Authorization #	Start Date (MMDDCCYY)	End Date (MMDDCCYY)	Type of Bill	Revenue Code (Service Code)	Place of Service	HCPCS/CPT (Service Code)	Primary Diagnosis Code	1	2	3	4	Disclaimer Codes (optional)	Total Units	Total Charges ($)
123456789	Member	Name	A	01011990	100009999999	11012022	11282022				S9125		UA					28	$ 2,800.00
123456789	Member	Name	A	01011990	100008888888	11292022	11302022		0243									2	$ 200.00

Claim Submission via PC-ACE (Providers must be registered to use PC-ACE)

- When billing Respite in PC-ACE, it must be billed as a "Professional" Claim

On this screen, be sure you select '**Professional**' then click '**View/Update**':



- Please refer to the PC-ACE Professional Claim Quick Start Guide for assistance with the setup for professional claims and completing the claim in PC-ACS
    - https://www.wpshealth.com/resources/files/pcace_pro32_familycare_prof_quickstart.pdf

- If additional assistance is needed with PC-ACE Claims, please outreach to the EDI help desk: **800-782-2680 (Option 1)**

Additional Considerations

- If a member goes absent while under a respite stay, a member absence rate authorization is not issued.
- Day of Discharge is not a paid day for respite. Example: Member enters respite on Friday for the weekend. Member discharges on Sunday. 2 days of respite are authorized, as Sunday is not a paid day.
- If a member's short-term respite stay transitions to a longer-term placement, a new authorization with a new authorization number will be issued for a Single Daily rate and the respite auth will end.
- This tip sheet references the most commonly used claim submission options (Paper Claim, Move it, and PC ACE). Though less common, respite can also be billed on a UB-04 & CMS-1500 Claim form as well as through other billing clearinghouses.
- Nursing Home providers can follow this same tip sheet for Respite Billing. Nursing Home respite is contracted under code and modifier: S9125 UB – 1 unit = 1 day

Resources

- Fillable Family Care Paper Claim Form: https://www.wpshealth.com/resources/files/fc-inclusa-claim-form-fillable.pdf
- Family Care Paper Claim Form Outline: https://www.wpshealth.com/resources/files/33226-famc-claim-form-outline.pdf
- Self-Register to use Move It spreadsheet/EDI: https://communitymanager.wpsic.com:16811/tcm/
- Move It Spreadsheet Instructions: https://www.inclusa.org/wp-content/uploads/MoveIT-Claim-Instructions.pdf
- PC ACE Software Download and User Guides for Professional and Institutional Claims: PC-ACE Claim Filing Options | WPS (wpshealth.com)
- For assistance with Authorization and Claims questions, please contact:
  ACS-Residential-CSL-NH@inclusa.org
  Phone: 1-888-544-9353, Option 6