

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.
 - \circ 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:

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Procedure/Service Code: S9125
Modifier 1: UA
Modifier 4:
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- 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 ٠ code S9125 UA. 1 day = 1 unit under code S9125 UA. This claim is completed correctly.

| | | | | |] | INC | LUS | A C | LAIM FORM | V | VPS. | INSURANCE |
|--|---------------------------|-----------------------------------|--|-------------------------|---------|------------------|---------------------------|----------------------------------|--|--|-----------------------|-----------------------------------|
| | | | | | | Μ | IEME | BER | INFORMATION | | | |
| 1. Member Ide | entification #: | 1234567 | '89 | | | | | | 4. Member Date of Birth: | 01/01/1900 | | |
| 2. Member Las | st Name: | Member | | | | | | | 5. Member First Name: | Name | | |
| 3. Primary Dia (Optional): | agnosis Code | | | | | | | | 6. Patient Account (invoice) #: | | | |
| | PRO (SERVIO | VIDER S | ERVICING | ADDRESS SS ADDRESS) | | | | | P (PHYS | ROVIDER BILLING ADI | DRESS G ADDRESS) | |
| 7. Provider TA | AX/EIN/SSN: | 99999999 | 99 | | | | | | 11. Provider Billing NPI #: | | | |
| 8. Business Na | me: | Provide | r A | | | | | | 12. Billing Provider Name: | Provider A | | |
| 9. Business Ad | ldress: | Provide | r Address A | | | | | | 13. Billing Address: | Provider Address A | | |
| 10. City/State/Z | Zip Code: | City, Sta | ate, Zip Code | e A | | | | | 14. City/State/Zip Code: | City, State, Zip code A | | |
| 15. Date of Service (MM/DD/YY) (Date Span or Individual Days) The Type of Bill 17. Revenue 18. HCPCS/ 1 18. Type of Bill | | | | | | 19. Mo | difiers 3 | 4 | 20. Authorization Number | 21. Rendering Provider NPI # | 23. (\$) Total Charge | |
| 11/01/22 | 11/01/22 | | Cout | \$9125 | UA | | | | 100009999999 | | 1 | 100.00 |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| 26. Disclaimer (| Code: I certify 25. Au | that all se | rvices indicated | above have be | een pro | ovided | . (Clai | ms for P | rervices must reflect actual services Provider A | es provided.) 11/21 Date: | /2022 | 24. (\$) Total Charges: 100.00 |
| | | Claim Re *One men *One auth | minders: nber per claim orization numb | form er per claim li | ne | Cla WP 800 | im Sta S Fan -223-0 | atus (nily Ca 5016 | Questions: Please M are Contact Center: Family C c/o WPS | ail this Claim Form to: are Health Insurance | | |

*One member per claim form *One authorization number per claim line *Use same service code that is listed on the Inclusa Service Authorization form Family Care c/o WPS Health Insurance P.O. Box 211595 Eagan, MN 55121 or FAX: 608-327-6332 (Do NOT include coversheet)

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• 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.



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|--|---|-----------|--|-------------------------|--|--------|--------------|--------|---|--|----------------------------|----------------------------------|--|--|--|--|--|
| 1. Member Id | lentification #: | 1234567 | /89 | | | | | | 4. Member Date of Birth: | 01/01/1900 | | | | | | | |
| 2. Member La | ast Name: | Member | | | | | | | 5. Member First Name: | Name | | | | | | | |
| 3. Primary Di (Optional): | iagnosis Code : | | | | | | | | 6. Patient Account (invoice) #: | | | | | | | | |
| | PR (SER | OVIDER S | ERVICING | ADDRESS SS ADDRESS) | | | | | P (PHYS | ROVIDER BILLING ADE | DRESS 5 ADDRESS) | | | | | | |
| 7. Provider T. | AX/EIN/SSN: | | | | | | | | 11. Provider Billing NPI #: | YSICIAN'S OR SUPPLIER'S BILLING ADDRESS) | | | | | | | |
| 8. Business Na | ame: | Provide | r A | | | | | | 12. Billing Provider Name: | Provider A | | | | | | | |
| 9. Business Ac | ddress: | Provide | r Address A | | | | | | 13. Billing Address: | Provider Address A | | | | | | | |
| 10. City/State/ | Zip Code: | City, Sta | ate, Zip A | | | | | | 14. City/State/Zip Code: | City, State, Zip A | | | | | | | |
| 15. Date of S (Date Span o | Service (MM/DD/YY) or Individual Days) | 16. Type | 16. Type of Bill 17. Revenue 18. HCPCS/ | | | 19. Mo | difiers 3 | 4 | 20. Authorization Number | 21. Rendering Provider NPI # | 22.Units Billed | 23. (\$) Total Charge | | | | | |
| 11/01/22 | 11/01/22 | | Coue | T1005 | | | | | 100009999999 | | 4 | 20.00 | | | | | |
| | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 26. Disclaimer Code: I certify that all services indicated above have been provided. (Claims for 25. Authorized Signature: Provider A Provider A | | | | | | | | ms for | rervices must reflect actual servic Provider A rint Name: | es provided.) 12/01 Date: | /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)

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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.

| | | | | |] | INCI | LUS | A CI | LAIM FORM | V | VPS. | HEALTH INSURANCE |
|---------------------------------|---|---------------------------------|------------------|----------------------------|--------|----------------|---------|--------|---|---------------------------------|----------------------|------------------------------------|
| | | | | | | Μ | EMI | BER I | INFORMATION | | | |
| 1. Member Ide | ntification #: | 1234567 | '89 | | | | | | 4. Member Date of Birth: | 01/01/1900 | | |
| 2. Member Las | st Name: | Member | | | | | | | 5. Member First Name: | Name | | |
| 3. Primary Dia (Optional): | gnosis Code | | | | | | | | 6. Patient Account (invoice) #: | | | |
| , _ | PRO (SERVI | VIDER S | ERVICING | ADDRESS SS ADDRESS) | | | | | P (PHY) | ROVIDER BILLING AD | DRESS IG ADDRESS) | |
| 7. Provider TA | X/EIN/SSN: | | | | | | | | 11. Provider Billing NPI #: | | | |
| 8. Business Nat | me: | Provider | r A | | | | | | 12. Billing Provider Name: | Provider A | | |
| 9. Business Ad | dress: | Provider | r Address A | | | | | | 13. Billing Address: | Provider Address A | | |
| 10. City/State/Z | Lip Code: | City, Sta | ate, Zip A | | | | | | 14. City/State/Zip Code: | City, State, Zip, A | | |
| 15. Date of Se (Date Span or | rvice (MM/DD/YY) Individual Days) | 16. Type | Servic | e Code 18. HCPCS/ | 1 | 19. M o | difiers | 4 | 20. Authorization Number | 21. Rendering Provider NPI # | 22.Units Billed | 23. (\$) Total Charge |
| From Date | To Date | 01 DIII | Code | СРТ | | 2 | 3 | 4 | | | Dilleu | |
| 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 certit | fy that all ser uthorized Si | rvices indicated | above have be rovider A | en pro | ovided. | (Clai | ms for | services must reflect actual services reflect actual service Provider A | bes provided.) 12/0 Date: | 1/2022 | 24. (\$) Total Charges: 3000.00 |

INCLUSA CLAIM FORM

Claim Status Ouestions: 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

FAX: 608-327-6332 (Do NOT include coversheet)

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Claim Reminders:

*One member per claim form

Inclusa Service Authorization form

*One authorization number per claim line

*Use same service code that is listed on the

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.

• <u>Example #1 – Clean Correct Claim</u>: 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.

| DD OLUD DD I | | | | | | | | | | | | | | | | | | | | |
|---------------------|-----------------------|--------------------|------------------------------|---------------------------------|-----------------------|------------------------------|----------------------------|----------------------------|--------------------------------|-------------------------------|-----------------------------|------------------------------|------------------------|--------|---------|-------|-----------------------------------|-------------|-------------------|--|
| PROVIDER I | NFORMATION | : | | | | | | | | | | | | | | | | | | |
| Provider TAX ID/I | EIN/SSN: | 9999999999 | | | | Location # (res | erved for WPS): | | | | | | Group | Name | or Pro | ogram | Name: | MCO Name | | |
| Provider Billing N | PI #: | | | | | Pend (reserved | for WPS): | | | | | | Provider Contact Name: | | | | | Biller Name | | |
| Servicing or Busine | ess Provider Name: | Provider A | | | | Billing or Pay- | o Provider Nam | e: | Provider A | | | | Provid | ler Co | ntact E | mail: | | Biller Emai | 1 | |
| Servicing or Busine | ess Provider Address: | Provider Address A | | | | Billing or Pay- | o Provider Addı | ress: | ProviderAdd | ress A | | | Provid | ler Co | ntact P | hone: | | Biller Phon | e | |
| City: | | City | | | | City: | | | City | | | | | | | | | | | |
| State: | | State | | | | State: | | | State | | | | Open ' | Text: | | | | | | |
| Zip Code: | | Zip Code | | | | Zip Code: | | | Zip Code | | | | | | | | | | | |
| CLAIM DET | AIL INFORMAT | TION: | | | 3000C03000C03000C0300 | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | 1 | | | |
| | Memb | er Information | | | | Date(s) | of Service | UB-04 Institutional | | stitutional 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 (S) | |
| 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 # (rese | erved for WPS): | | | | | | Group | Name o | r Progr | ım Name: | MCO Nam | e |
| Provider Billing NPI #: | | Pend (reserved for WPS): | | | | | | | | | iet Nam | e: | Biller Name | | | |
| Servicing or Business Provider Name: | Provider A | | Billing or Pay-t | o Provider Nam | e: | Provider A | | | | Provide | r Cont | ict Ema | il: | Biller Email | | |
| Servicing or Business Provider Address: | Provider Address A | | | Billing or Pay-t | o Provider Addr | ess: | ProviderAdd | ress A | | | Provide | r Cont | ict Phoi | ie: | Biller Phon | e |
| City: | City | | | City: | | | City | | | | | | | | | |
| State: | State | | | State: | | | State | | | | Open T | ext: | | | | |
| Zip Code: | Zip Code | | | Zip Code: | | | Zip Code | | | | | | | | | |
| CLAIM DETAIL INFORMAT | TION: | | | | | | | | | | | | | | | |
| Memb | er Information | | | Date(s) o | f Service | UB-04 | Institutional | HCFA | Professional | | | Modif | ier | | | |
| Member ID # First Name | Midd Name Last Name Initia | e Date of Birth or (MMDDCCYY l) | 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 | Disclaime Codes 4 (optional) | Total Units | Total Charges (\$) |
| 123456789 Member | Name A | 01011990 | 1000099999999 | 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 I | NFORMATION | : | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|---|--|--|-------------------------------|---|-----------------------------|--|------------------------------|-------------------------|-----------|------------|---------|-----------------------------------|------------------------|----------------|--------------------------------------|
| Provider TAX ID/E | IN/SSN: | 9999999999 | | | | Location # (res | erved for WPS): | | | | | | Group | Name | or Pro | ogram l | Name: | MCO Nam | e | |
| Provider Billing NP | 'I #: | | | | Pend (reserved for WPS): | | | | | | | Provid | ler Con | itact Na | ame: | | Biller Name | | | |
| Servicing or Busines | ss Provider Name: | Provider A | | | | Billing or Pay-to Provider Name: | | | Provider A | | | | Provider Contact Email: | | | | | Biller Email | | |
| Servicing or Busines | ss Provider Address: | Provider Address A | | | | Billing or Pay-t | o Provider Addr | ess: | ProviderAdd | ress A | | | Provid | ler Con | itact Pl | hone: | | Biller Phone | | |
| City: | | City | | | | City: | | | City | | | | | | | | | | | |
| State: | | State | | | | State: | | | State | | | | Open ' | Text: | | | | | | |
| Zip Code: | | Zip Code | | | | Zip Code: | | | Zip Code | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| CLAIM DETA | IL INFORMAT | TION: | | | | | | | | | | | | | | | | | | |
| CLAIM DETA | IL INFORMAT Memb | TION: per Information | | | | Date(s) o | f Service | UB-04 | Institutional | HCFA | Professional | | | Mod | ifier | | | | | |
| CLAIM DETA | IL INFORMAT Memb First Name | Last Name | Middle Name or Initial | Date of Birth (MMDDCCYY) | Authorization # | Date(s) of Start Date (MMDDCCYY) | f Service End Date (MMDDCCYY) | UB-04 Type of Bill | Institutional Revenue Code (Service Code) | HCFA Place of Service | Professional HCPCS/CPT (Service Code) | Primary Diagnosis Code | 1 | Modi 2 | ifier 3 | 4 | Disclaimer Codes (optional) | Total Units | Tota | l Charges (\$) |
| Member ID # 123456789 | IL INFORMAT Memb First Name Member | ION: er Information Last Name Name | Middle Name or Initial A | Date of Birth (MMDDCCYY) 01011990 | Authorization # 100009999999 | Date(s) of Start Date (MMDDCCYY) 11012022 | f Service End Date (MMDDCCYY) 11282022 | UB-04 . Type of Bill | Institutional Revenue Code (Service Code) | HCFA Place of Service | Professional HCPCS/CPT (Service Code) S9125 | Primary Diagnosis Code | 1 UA | Moda 2 | ifier 3 | 4 | Disclaimer Codes (optional) | Total Units 28 | Tota S | l Charges (\$) 2,800.00 |
| CLAIM DETA Member ID # 123456789 123456789 | IL INFORMAT Memb First Name Member Member | Last Name Name Name | Middle Name or Initial A A | Date of Birth (MMDDCCYY) 01011990 01011990 | Authorization # 100009999999 100008888888 | Date(s) o Start Date (MMDDCCYY) 11012022 11292022 | <i>Service</i> End Date (MMDDCCYY) 11282022 11302022 | UB-04 . Type of Bill | Institutional Revenue Code (Service Code) 0243 | HCFA Place of Service | Professional HCPCS/CPT (Service Code) S9125 | Primary Diagnosis Code | 1 UA | Modi 2 | ifier 3 | 4 | Disclaimer Codes (optional) | Total Units 28 2 | Tota S S | d Charges (S) 2,800.00 200.00 |
| CLAIM DETA Member ID # 123456789 123456789 | ILL INFORMAT Memb First Name Member Member | FION: Last Name Name Name | Middle Name or Initial A A | Date of Birth (MMDDCCYY) 01011990 01011990 | Authorization # 100009999999 10000888888 | Date(s) o Start Date (MMDDCCYY)) 11012022 11292022 11292022 | <i>Service</i> End Date (MMDDCCYY) 11282022 11302022 | UB-04 . Type of Bill | Institutional Revenue Code (Service Code) 0243 | HCFA Place of Service | Professional HCPCS/CPT (Service Code) S9125 | Primary Diagnosis Code | 1 UA | Modi 2 | ifier 3 | 4 | Disclaimer Codes (optional) | Total Units 28 2 | Tota S S | l Charges (\$) 2,800.00 200.00 |

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':

| 1 | 👖 Submit | ter Setup | | | - 🗆 🗙 |
|---|-------------|----------------|-------------------|----------------|-------|
| Γ | Claim Type: | C Institutiona | al 💽 Profession | a | |
| | LOB | Payer ID | Submitter ID/EIN | Submitter Name | ^ |
| | << ALL >> | << ALL >> | YOUR ID HERE | SUBMITTER NAME | |
| | | | | | |
| | New | | date <u>C</u> opy | <u>D</u> elete | Cļose |

- 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
 - <u>https://www.wpshealth.com/resources/files/pcace_pro32_familycare_prof_quickstart.pd</u>
 <u>f</u>
- 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: <u>https://www.wpshealth.com/resources/files/33226-famc-claim-form-outline.pdf</u>
- Self-Register to use Move It spreadsheet/EDI: https://communitymanager.wpsic.com:16811/tcm/
- Move It Spreadsheet Instructions: <u>https://www.inclusa.org/wp-content/uploads/MoveIT-Claim-Instructions.pdf</u>
- PC ACE Software Download and User Guides for Professional and Institutional Claims: <u>PC-ACE Claim Filing Options | WPS (wpshealth.com)</u>

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 For assistance with Authorization and Claims questions, please contact: <u>ACS-Residential-CSL-NH@inclusa.org</u> Phone: 1-888-544-9353, Option 6