Guidance on Billing DDP claims – current issues (August 2019)

General Rule:

- For a defined date span, each code should have ONE line on a claim. Do not bill multiple claim lines with the same code and same date span. The only exception is if you are also billing for a Self-Direct service or a TSI and you have a modifier on the 2nd claim line.
- When entering the claim information for the individuals you serve, use the **Recipient ID** listed on your prior authorization letters as their Member ID on the claim.
- For each line on a claim, you must enter at least 1 unit in order for it to process.
- Definitions of units are in the Manual.

Transportation:

- Claims that have 2 lines with procedure code T2003 and the same date span have been delaying payments. Please go to https://dphhs.mt.gov/dsd/developmentaldisabilities/ddpforms-tool and read the Transportation Billing Guidelines. There you will find instructions on how to properly bill for all of the transportation categories. If you submitted claims with 2 lines of the T2003 procedure code, those claims will be forced to process and providers don't have to do adjustments. Based on the billing guidelines, please ensure you are billing T2003 correctly in the future.
- There is a system issue when 2 providers are billing the same transportation code on the same day. There is a system instruction update where this will be allowable for DDP and claims (present and future) will be processed.
- Issues for transportation other than the two above will likely have the claim line deny. If you have incorrectly billed transportation for reasons other than the two above and the claim was paid (wrong units, wrong amount, etc.) then we anticipate that providers will do adjustments to get those corrected.

Diagnosis Codes:

- Some providers have experienced an issue with the Optum billing and diagnosis codes. One example has been the Medicaid requirement of decimals for some specific diagnosis, however, the tool on the claim form is allowing a provider to pick the more generic diagnosis code on the claim. A request will be submitted to Optum to only show and allow diagnosis codes that meet the Medicaid requirements for payment to be chosen from their list on the claim.
- Diagnosis code website by Conduent: https://icd10coded.com/

Units:

- Providers have reported some issues with entering units that are more than 3 digits. MMIS does not accept decimals when entering units and providers can only bill for whole-unit increments, so this may be part of the issue. Refer to the Manual for the definitions of units.
- Although MMIS will never allow decimals to be entered in the units, Conduent is looking into the units and whether a system update is necessary to allow more digits to be entered. If providers are experiencing problems entering 3 digits for their units, there is the option of billing smaller date spans so units don't exceed 2 digits. Since the date spans do not overlap, the below example will process for payment:

MOCK CLAIM

Diagnosis Codes (ICD 10)

1 F70	2	3	4	5	6
7	8	9	1	11	12

From Date	To Date	POS	CPT/HCPS	Modifier	Diagnosis pointer	Charges	Days or Units	COB / NDC/ EPSDT	Emergency service	Family Planning
7/1/2019	7/15/2019	99	T2013		1	$ 1,467.60	60			
7/16/2019	7/31/2019	99	T2013		1	$ 1,467.60	60			
						$				
**example of SL hourly					Total Charges	$ 2,935.20	Add			

- Day Services - when billing day services when you also have program-related days, use 1 claim line. Determine the number of 'regular' days (in the date span) and the number of program-related days that are appropriate (considering their planned attendance). Add up the total days for both, and add up the total charges for both. (Example: 20 attended days and 1 program related day is a total of 21 days. Calculate 20 days at the person's regular rate, and 1 day at their program-related rate. Add them all together for total days and total charges for 1 claim line)
- Supported Living Flex and Base, and Supported Employment Follow Along monthly units – 1 unit is billed per month. There may be situations where the hours provided do not meet the minimum of hours for a certain monthly unit. Since decimal units cannot be billed, you will bill 1 unit, and enter the amount of the monthly unit that the person DOES qualify for based on what was actually delivered. For example, a person is in Tier 2 Supported Employment Follow Along. The range of hours is 22 to 31.9. For this example if only 10 hours was delivered, it's appropriate to bill at the BASE rate (up to 10.5). You enter H2025, enter 1 unit, and for the charges you enter the BASE rate at $407.61.

Procedure Codes:

- Use your Budget v. YTD report to identify what services a person is in (and Tiers for the daily rates). Use the fee schedule to determine the proper code(s) and amount to bill for that service based on the units you provided. Cross check with what is listed on the prior authorization letters.
- PERS and Specialized Medical Equipment and Supplies require the breakout of billing. On the Budget v. YTD report and your prior authorization letters, these are listed as a single service. However, when you look at the rates sheet you will notice each service actually has two codes assigned. Look at the descriptions on the rates sheet closely and break out those services into each separate code that is appropriate for what you are billing. You may be billing both codes for the same time frame and that's ok…it's not duplicative since each code will have their own line on the claim.

Example of how PERS and Specialized Medical Equipment and Supplies looks on the Budget v. YTD report:

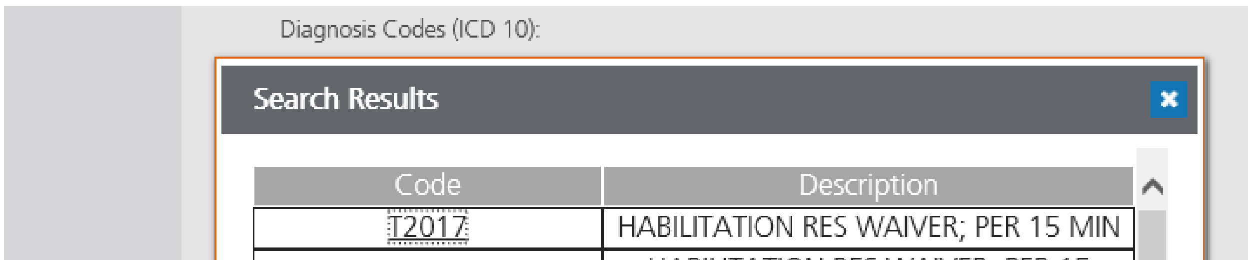
Service Category	Service Detail Code	Service Detail	Reporting Service
Individualized Supports	638	Specialized Med Equip Supplies	Specialized Med Equip Supplies
Individualized Supports	618	PERS	PERS

Excerpt from the Summary Rates Sheet showing 2 codes:

T2029		Specialized Medical Equipment	7/1/2019
T2028		Specialized Medical Supplies	7/1/2019
S5160		Personal Emergency Response System (Installation & Testing)	7/1/2019
S5161		Personal Emergency Response (Monthly Service)	7/1/2019

- Some codes have national descriptions in the claim form that might be confusing. Do not convert units to fit the descriptions you may see, if the description is different than any billable unit as described in the fee schedule.

Example from Optum claim:



Code T2017 for DDP does not have this unit assigned on the DD fee schedule. Do not convert units when billing. Please use the unit appropriate for that person per the Budget v. YTD report and the fee schedule. This is just 1 example and there are more like this you may encounter. If you inappropriately converted units, those claims will need to be adjusted.

General Claims and Processing:

- Claims cycle every Monday and Wednesday night. Payments are made by direct deposit every Monday (unless there is a holiday). Your Statement of Remittance is available every Tuesday (unless you have no claims in process for that claim cycle). Normally electronic claims with no errors submitted by 2:30PM on a Wednesday will pay on the following Monday. However, claims containing errors could take up to 30 days to process. Unforeseen technical/system issues can also delay payment. Paper claims take much longer to process.
- If you have specific questions on a claim you can contact Provider Relations at 800-624-3958 or email mtprhelpdesk@conduent.com. Additionally, Deb Braga has offered to be a point of contact for detailed questions or adjustment questions.

REMINDER: Although they may overlap, there are Q&A and other training or reference materials at:

https://dphhs.mt.gov/dsd/developmentaldisabilities/mmistransition and

https://medicaidprovider.mt.gov/82

https://medicaidprovider.mt.gov/faqs Frequently Asked Questions (not specific to DDP)

https://icd10coded.com/ ICD-10 diagnosis codes