LTSS Billing Guidelines

Optima Health Community Care

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Long Term Services and Supports (LTSS) Billing

These are the billing guidelines for Long Term Services and Supports (LTSS) providers submitting paper claims for Optima Health Community Care (OHCC) members. This document is intended as a guide only; further detail regarding Optima Health Community Care claims policies and procedures is available in the Optima Health Provider Manual/OHCC Supplement on www.optimahealth.com/providers.

Electronic billing is the preferred method of claims submission.

Submit your claims online! Optima Health offers online claims submission for LTSS claims through the PCH Claims Portal. Registration for PCH is required; please contact CENTIPEDE Health at 1-855-359-5391 to obtain your secure login and instructions for online claims billing.

Optima Health also accepts electronic claims from any clearinghouse that can submit to AllScripts. Optima Health's Payor ID for electronic transactions is 54154.

Any paper claims should be mailed to:

Optima Health Community Care
P.O. Box 5028
Troy, MI 48007-5028

The only acceptable CMS 1500 claim forms are those printed in Flint OCR Red, J6983, (or exact match) ink, to allow data in fields to be scanned and entered into our claims processing system. Claims submitted on copies will require manual review and cause a delay in processing and payment.

Need help completing a CMS 1500 form or submitting a claim online?
CENTIPEDE Health Network offers one-on-one assistance and training on preparing the CMS 1500 for submission to Optima Health Community Care. If you require this assistance, please contact CENTIPEDE at joincentipede@heops.com or 1-855-359-5391.

centipede HEALTH NETWORK

ALL CLAIMS MUST BE FILED WITHIN 365 DAYS FROM THE DATE OF SERVICE TO BE ELIGIBLE FOR REIMBURSEMENT.

If you have any questions about the information in this guide, please contact ***Optima Health Community Care Provider Relations at 1-844-512-3172.***

Verifying Member Eligibility

Always check member eligibility prior to providing services. This is an important step to ensuring reimbursement. Verification may be obtained by:

Provider Connection: www.optimahealth.com/providers (Secure login required. Register here.)

or

Optima Health Community Care Provider Relations: 1-844-512-3172

Completing the CMS 1500 Form

This information specifies what information must be entered in each field of the CMS 1500 form in order for your claim to be processed by Optima Health Community Care. **Submitting claim forms without the required information may either significantly delay payment or prevent claims from processing altogether.** Please review all claims for accuracy and completion prior to submitting to Optima Health Community Care (OHCC). (Comprehensive instructions for completing the CMS 1500 form can be found on the National Uniform Claim Committee website at www.nucc.org.)

FIELD	TITLE	OHCC GUIDELINES	REQUIRED
1	Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	Indicate the type of health insurance coverage applicable to this claim by placing an X in the MEDICAID box. Only one box can be marked.	Y
1a	Insured's ID No.	Enter the patient's **entire** Optima Health Community Care Member ID number, including the 2 digits after the asterisk (*). This number can be found under the member's name on the OHCC member ID Card. *Please do not include the asterisk (*) in this field.*	Y
2	Patient's name	Enter the patient's last name, first name, and middle initial as printed on the Optima Health Community Care Member ID card.	Y
3	Patient's date of birth and sex	Enter the month, day, and year (MM/DD/YYYY) the patient was born. Indicate the patient's gender by checking the appropriate box. Only one box can be marked.	Y
5	Patient's address	Enter the patient's complete address (street, city, state, and zip code).	Y

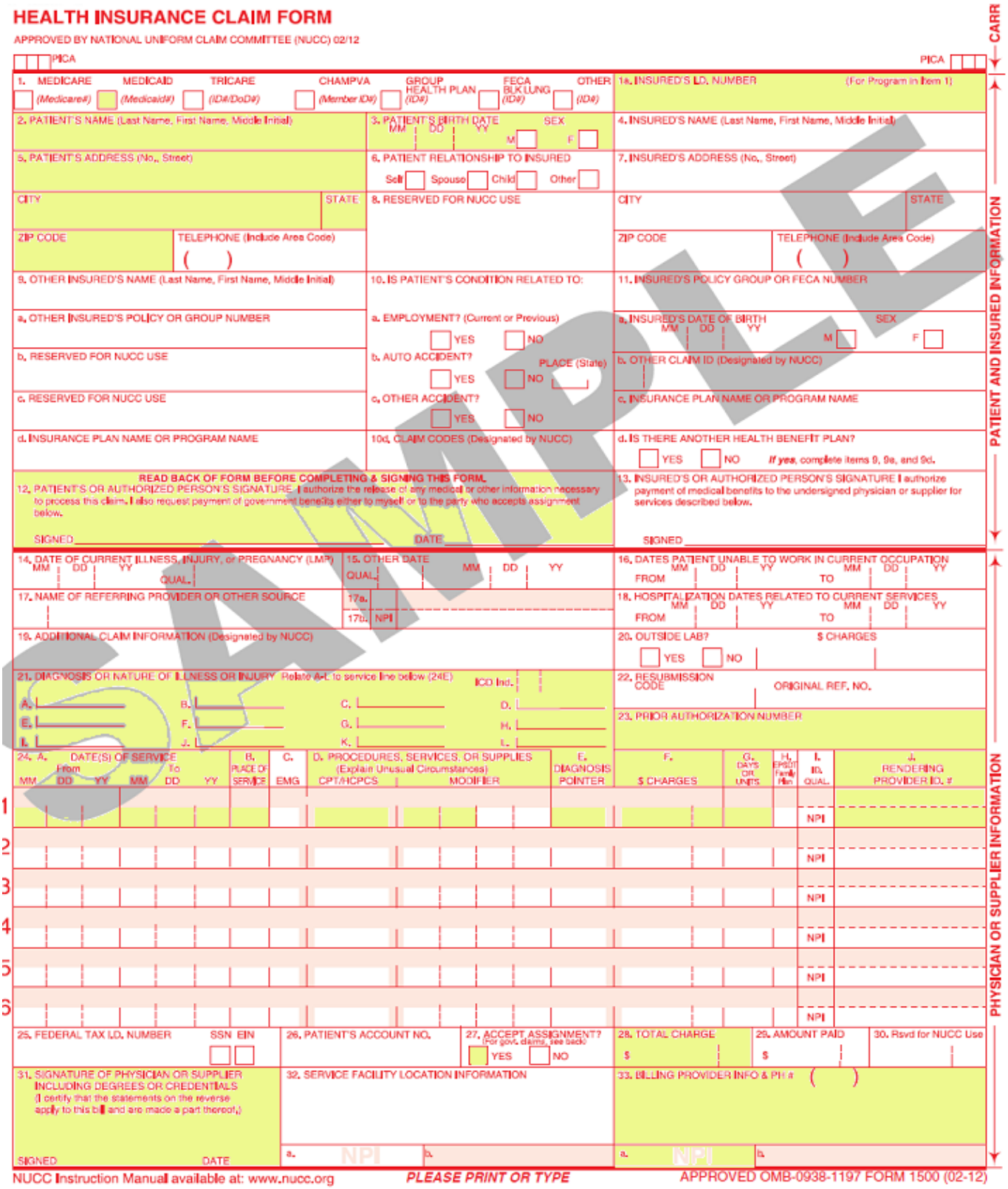
9 9a	Other insured's name Policy or Group number	**If applicable:** Required when additional group health coverage exists.	N
12	Patient's or authorized person's signature	Enter signature, "Signature on file" or "SOF. " If there is no signature, leave blank or enter "No signature on file."	Y
14	Date of current illness, injury or pregnancy (LMP)	**If applicable:** Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period.	N
17 17a 17b	Name of referring physician or other source a. ID number of other provider b. NPI of other provider	**If applicable:** Enter the complete name (Field 17) and the NPI (Field 17b) of the referring, ordering, or supervising provider.	N
21	Diagnosis or nature of illness or injury	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM Enter the patient's diagnosis and/or condition codes. List no more than twelve diagnosis codes to the highest level of specificity available.	Y
22	Resubmission and/or original reference number	When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field. 7 - Replacement of prior claim. 8 - Void/cancel of prior claim. Then list the original reference number for resubmitted claims.	N
23	Prior authorization number	Enter the authorization number	Y
24a	Date(s) of service	Enter the date of service for each procedure provided in the unshaded portion of the field. Dates should be in MM/DD/YY format.	Y
24b	Place of service	Enter the appropriate Place of Services (POS) code for each service in the unshaded portion of the field.	Y

24d	Procedures, services, or supplies	Enter the appropriate procedure codes and modifiers in the unshaded portion for each service. Please see authorization letter for approved procedure codes and modifiers.	Y
24e	Diagnosis pointer	Enter the line item reference (A-L) of each diagnosis code identified in Field 21 for each procedure.	Y
24f	Charges	Enter the usual and customary charges for each service listed in the unshaded portion of the field. Charges must not be higher than fees charged to private-pay clients.	Y
24g	Days or units	Enter the number of services (quantity) performed for each service line item billed (such as days, units, hours).	Y
24j	Rendering provider ID #	• Enter the provider's NPI number in the bottom, unshaded portion of the field (labeled NPI). • Enter the taxonomy number in the top, **shaded** area of the field, above the NPI.	Y
25	Federal tax ID number	Enter either the Tax ID number (TIN) or SSN number along with the appropriate check box.	Y
26	Patient's account number	Optional: Enter the patient account number (used by provider's office to identify internal patient account number).	N
27	Accept assignment	Enter an X in the correct box. Only one box can be marked.	Y
28	Total charge	Enter the total charges. • For multi-page claims enter "continue" on initial and subsequent claim forms and enter the total charges on the last claim .	Y
29	Amount paid	Optional: Enter any amount paid by an insurance company or other sources known at the time of submission of the claim.	N

31	Signature of physician or supplier	The physician, supplier, or authorized representative must sign and date the claim. Billing services may enter "Signature on file" or "SOF" in place of the provider's signature if the billing retains on file a letter signed by the provider authorizing this practice.	Y
32	Service facility location information	**If applicable:** If services are provided in a place other than the client's home or the provider's facility/office, enter the name, address, city, state and zip code of the facility/office where the service was provided.	N
33	Billing provider info and phone number	Enter the billing provider's name, street, city, state, zip+4 code, and telephone number.	Y
33a	NPI	Enter the NPI of the billing provider	Y

- If more than six line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28 line items for the entire claim.
- For multi-page claim forms, indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the claim form.

Sample CMS 1500 form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Billing Guidelines by Service

Click here to view the full list of DMAS LTSS Procedure Codes, Modifiers, and Rates for CCC Plus (effective 7/1/17) on www.dmas.org.

Adult Day Care

Service Description	Place of Service	CPT	Modifier	Days or Units
	24B	**24D**	**24D**	**24G**
ADHC Services	99	S5102		Per Diem
Transportation	99	A0120		Per Trip

ADHC Services should be billed as per diem; transportation should be billed per trip.

Assistive Technology (AT)/Maintenance

Service Description	Place of Service	CPT	Modifier	Days or Units
	24B	**24D**	**24D**	**24G**
Assistive Technology (AT)	99	T1999		Limited to per item
AT Maintenance	99	T1999	U5	Limited to per item

AT and AT Maintenance cannot exceed the $5,000 benefit limit.

Environmental Modifications (EM)/Maintenance

Service Description	Place of Service	CPT	Modifier	Days or Units
	24B	**24D**	**24D**	**24G**
Environmental Modifications (EM)	99	S5165		Limited to per item
EM Maintenance	99	99199	U4	Limited to per item

EM and EM Maintenance combined costs cannot exceed the $5,000 benefit limit.

Personal Care

Service Description	Place of Service	CPT	Modifier	Days or Units
	24B	**24D**	**24D**	**24G**
Agency Directed (AD)	12	T1019		1 unit = 1 hour
Consumer Directed (CD)	12	S5126		1 unit = 1 hour

Personal Care Services are billed hourly.

Personal Emergency Response System (PERS)

Service Description	Place of Service	CPT	Modifier	Days or Units
	24B	**24D**	**24D**	**24G**
PERS Nursing (RN)	12	H2021	TD	1 unit = 1 hour
PERS Nursing (LPN)	12	H2021	TE	1 unit = 1 hour
PERS Installation	12	S5160		1 unit = 1 visit
PERS Installation and Medication Monitoring	12	S5160	U1	1 unit = 1 visit
PERS Monitoring	12	S5161		
PERS Medication Monitoring	12	S5161		

PERS Nursing Services are billed in 30 minute increments.
PERS installation (w/ or w/o medication monitoring) is billed as per visit.

Respite Care

Service Description	Place of Service	CPT	Modifier	Days or Units
	24B	**24D**	**24D**	**24G**
Agency Directed (AD)	12	T1005		1 unit = 1 hour
Consumer Directed (CD)	12	S5150		1 unit = 1 hour
PDN RN Respite Services	12	S9125	TD	1 unit = 1 hour

PDN LPN Respite Services	12	S9125	TE	1 unit = 1 hour
Congregate Respite RN Nursing Services	12	T1030	TD	1 unit = 1 hour
Congregate Respite LPN Nursing Services	12	T1031	TE	1 unit = 1 hour

Respite Care services are billed hourly.

Services Facilitation (SF)

Service Description	Place of Service	CPT	Modifier	Days or Units
	24B	**24D**	**24D**	**24G**
SF Initial Comprehensive Visit	12	H2000		1 unit = 1 visit
SF Consumer Training Visit	12	S5109		1 unit = 1 visit
SF Management Training Visit	12	S5116		1 unit = 1 visit
SF Routine Visit	12	99509		1 unit = 1 visit
SF Reassessment Visit	12	T1028		1 unit = 1 visit

Facilitation Services are billed as per visit

Skilled Private Duty Nursing

Service Description	Place of Service	CPT	Modifier	Days or Units
	24B	**24D**	**24D**	**24G**
PDN RN Nursing Services	12	T1002		1 unit = 1 hour
PDN LPN Nursing Services	12	T1003		1 unit = 1 hour
Congregate RN Nursing	12	T1000	U1	1 unit = 1 hour
Congregate LPN Nursing	12	T1001	U1	1 unit = 1 hour

Skilled PDN is covered up to 16 hours per day; 112 hours per week.
These services are billed hourly.

Transition Services

Service Description	Place of Service	CPT	Modifier	Days or Units
	24B	**24D**	**24D**	**24G**
Transition Services	99	T2038		

Transition Services are limited to a total cost of $5,000.00 per lifetime

CONTACT US

OPTIMA HEALTH COMMUNITY CARE PROVIDER RELATIONS

Phone: 1-844-512-3172

CLINICAL CARE SERVICES

Prior Authorization - Medical and Pharmacy
Phone: 1-888-946-1167
Fax numbers for specific services are located on the authorization fax forms
www.optimahealth.com/providers

Prior Authorization - Behavioral Health
Phone: 1-888-946-1168
Inpatient Fax: 1-844-348-3719
Outpatient Fax: 1-844-895-3231

Prior authorization forms are available on **www.optimahealth.com/providers**

Care Coordination
Phone: 1-866-546-7924
Fax: 1-844-828-0600

After Hours Nurse Program

Phone: 1-844-387-9420

CENTIPEDE HEALTH NETWORK

Phone: 1-855-359-5391
E-mail: joincentipede@heops.com