AllyAlign Health

PRACTICE GROUP BILLING OVERVIEW

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CONTENTS

SECTION 1: OVERVIEW

This overview is to provide billing guidance; however, this document is not intended to provide instruction on *how* to bill. For any questions specifically related to plan claims submission, please reach out to the claims department.

Statement of Medicare Benefits: The Special Needs Plan is designed to improve the care of Members enrolled into the Plan. Our Members are Medicare beneficiaries who meet the requirements of eligibility.

For additional details, the Evidence of Coverage or Summary of Benefits is listed on the Plan website.

This content is current as of **March 21, 2022**.

SECTION 2: SUBMISSION OF CLAIMS

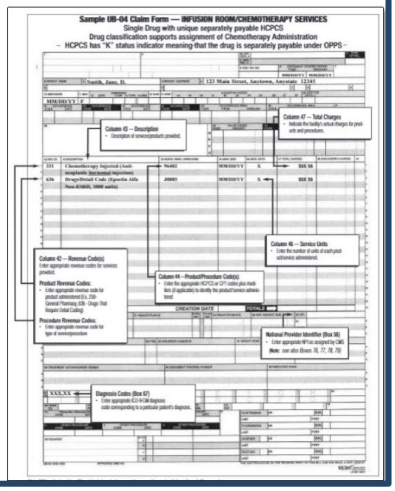
- The Plan follows all Medicare guidelines pertaining to timely filing requirements (12 months from date of service)
  - Cannot bill future date of service

- Acceptable claim forms:
  - CMS 1500 for Professional Claims

- Claims can be submitted via paper, EZ-Net, or SSI Claimsnet
  - Mail paper claims to: P.O. Box 21593, Eagan, MN 55121
  - The Plan name should be listed on the envelope

CMS 1500 for Professional Claims

UB04 Claim Form



- Billing Resources: **EZ-Net**
  EZ-Net Provider Portal offers Providers secure, web-based access to healthcare information, including claims, eligibility, and benefits.

- Functionality:
  - Member eligibility and benefits lookup
  - Claims submittal and inquiry
  - Authorization and referral inquiry
  - Research procedure codes, diagnostic codes, and other general reference information
- Please contact your Plan Account Manager additional information (i.e. webpage and training resources)
  - Plan-specific billing training is located:
    1. Plan EZ-Net webpage
    2. Plan webpage (Under the 'Providers and Partners' tab)
  - For EZ-Net support, contact eznetsupport@allyalign.com

- Billing Resources: **Electronic Billing**
  - Providers may submit claims through their clearinghouse and receive electronic remits
  - Contact your clearinghouse to request the Payer ID if not shown on your clearinghouse payer list
  - If your clearinghouse has any questions, please have the vendor contact SSI Claimsnet Customer Support at 800-356-0092 or via email at HelpDesk_Dallas@ssigroup.com.
  - Note: This helpdesk does not provide EZ-Net support

SECTION 3: BILLING RESOURCES

Click below for more information:	
Medicare Homepage	Anesthesiologists Center
Medicare MAC List	Rural Health Clinics Center
Physician Fee Schedule Look-Up Tool	Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule
Ambulance Fee Schedule	Ambulatory Surgical Center (ASC) Payment
Clinical Lab Pricing Information	ESRD (End Stage Renal Disease) Prospective Payment System
CMS Approved Telehealth Services *COVID-19 Response	CMS Approved Telehealth Services- Audio Only Acceptable *COVID-19 Response

**Information subject to change by CMS*

SECTION 4: PLAN PROVIDER/PRACTICE GROUP BILLING

HEDIS & STAR MEASURE DOCUMENTATION & BILLING

HEDIS® (Healthcare Effectiveness Data and Information Set) is a performance measurement tool developed by the National Committee for Quality Assurance (NCQA) to assess the quality of healthcare and improve patient health and outcomes. HEDIS® data is collected using medical claims, pharmacy claims, and sometimes medical records*. Medicare Managed Care Organizations are required by Centers for Medicare & Medicaid Services (CMS) to submit HEDIS® data.

Some HEDIS® measures are also part of the 5 – Star Quality Rating System that the Centers for Medicare & Medicaid Services (CMS) uses to evaluate Medicare Managed Care Organizations.

Not all Star Measures are HEDIS® measures. This guide (embedded below) includes select measures and was developed to ***assist network providers with understanding how to efficiently and accurately document and bill*** for certain preventive care and other services being provided.

Double-click tack to open attachment for:
HEDIS STAR Tips MY2022 March 2022.x

*Most measures can be satisfied by submitting the appropriate code on a claim. However, there are two measures (Breast Cancer and Colorectal Cancer Screening) that allow screenings performed historically to count. Please refer to specific details for additional guidance on submitting historical information.

QUALITY MEASURES/HEDIS CODING TIPS (CPT II)

When CPT Category II or ICD-10 – CM codes are added to a claim, it helps identify additional information about the Member's care. This method of reporting simplifies and improves accuracy of reporting select quality measures for both HEDIS and CMS Star Ratings reporting. The codes listed in the HEDIS Stars Tips document embedded above are for informational purposes only and this communication is not intended to suggest or guide reimbursement.

PLAN SPECIFIC BILLING:

The below CPT codes and definitions are meant to highlight the coding specific to the activity of the Plan Providers. This activity includes both Model of Care requirements and Plan-specific initiatives; it is not an all-inclusive list of codes that are payable for Plan Provider services. *The Plan Provider (or practice) should follow Medicare guidelines for billing procedures and visits not listed below.*

Billing Codes & Descriptions		
Billing Code	Visit Type	Assumptions:
96160	Health Risk Assessment (HRA)	Providers who use their own Health Risk Assessment Tool must submit this service code to indicate the completion of the initial and subsequent HRAs. **REMINDER: Providers who use WellAlign360 do not need to submit a claim to indicate completion.*
G0438	Annual Wellness Visit (initial)	Annual wellness visit; includes a personalized prevention plan of service (PPS), **initial** visit
G0439	Annual Wellness Visit (subsequent)	Annual wellness visit, includes a personalized prevention plan of service (PPS), **subsequent** visit
G0175	Interdisciplinary Care Team (ICT) Meeting	**Nursing Facility Conference (Practitioner Payment for Care Coordination and Caregiver Engagement):** This code is for Nursing Facility Conference (also referred to as an **Interdisciplinary Care Team meeting or Care Plan Meeting**). In order to bill for this service, the provider must conduct the discussion: 1. With the Member and/or individual(s) authorized to make health care decisions for the beneficiary (as appropriate); 2. In a conference for a minimum of 25 minutes; 3. Without performing a clinical examination of the Member during the discussion (this should be conducted as needed through regular operations and this session is focused on a care planning discussion); 4. With at least three members of the interdisciplinary care team and the provider must also document the conversation in the Member's medical chart. If you are providing Chronic Care Management (CCM) services for a Plan Member, you should not charge the extra ICT code. If you are following a Member or CCM, either use the CCM code OR the G0175 ICT code, but do not charge both within a 30-day period. Reminder: CCM codes must meet current CPT guidelines. Medicare Learning Network: Chronic Care Management Services
99497 (initial 30 mins) 99498 (ADDL 30 mins)	Advanced Care Planning (ACP)	Advance Care Planning includes the explanation and discussion of advance directives, such as standard forms (with completion of such forms, when performed), delivered by the physician or other qualified health professional; use CPT 99497 for the first 30 minutes of face-to-face review with the patient, family member(s) and/or surrogate]

		Use add-on CPT code 99498 for each additional 30 minutes of this same service (list separately on claim in addition to code for primary procedure)
99495 99496	Transition Care Management (TCM)	These services are for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living.) The Plan, for purposes of TCM billing, considers non-skilled Nursing Facility care (often called custodial, nursing home, or Medicaid bed) as a "home" setting in which Members benefit from TCM. TCM commences upon the date of discharge and continues for the next 29 days. The first face-to-face visit is part of the TCM service and not reported separately. Additional E/M services after the first face-to-face visit may be reported separately. TCM requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. The contact may be direct (face-to-face), telephonic or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit. **TCM services should be billed with a date of service of the face-to-face visit which must take place no later than 7 days of discharge per the Plan policy for both 99495 and 99496.** These services address any needed coordination of care performed by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activity of daily living support by providing first contact and continuous access. (Do not report 90951-90970 , 98960- 98962 , 98966- 98969 , 99071, 99078, 99080, 99090, 99091, 99339, 99340, 99358, 99359, 99363, 99364, 99366- 99368 , 99374- 99380 , 99441- 99444 , 99487- 99489 , 99605- 99607 when performed during the service time of codes 99495 or 99496).

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<tr><td>99495</td><td>o Initial communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
o Followed by a face-to-face visit within 14 calendar days of discharge</td></tr>
<tr><td>99496</td><td>o Initial communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
o Followed by a face-to-face visit within 7 calendar days of discharge</td></tr>
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Model of Care Coding: 99495 or 99496 is the correct code to use for a <u>Triggering Event</u> that most often results in a change in care level from Hospital to SNF. TCM codes should only be used by the Plan Provider on discharge from NF to community when the Plan Provider continues to follow the Member post-discharge for up to 30 days.
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<tr>
<td>G9685</td>
<td>Skill in Place (SIP)</td>
<td>Treatment of Conditions Onsite at Nursing Facility: This code is for the onsite response to an acute change in condition or a service is provided to evaluate "skill in place" services for a Member with (or suspected to have) one of the following diagnoses:

Acute Nursing Facility Care Descriptor: Used for the evaluation and management of a beneficiary's acute change in condition in a nursing facility and requires three key components: A comprehensive review of the beneficiary's history; a comprehensive examination; and medical decision making of moderate to high complexity. Also includes counseling and/or coordinating care with nursing facility staff and other providers or agencies consistent with the nature of the problem(s) and the beneficiary's/family's needs. This code can only be used for the first visit in an LTC facility in response to a beneficiary who has experienced an acute change in condition (to confirm and treat the diagnosed conditions). Follow-up or subsequent visits with the patient while still in a Skill in Place stay should use traditional rounding visit codes.</td>
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<tr>
<td>1494F</td>
<td>Cognitive Assessed and Reviewed</td>
<td>Cognitive Assessment: This code is the correct code for non-WellAlign360 performed Cognitive Assessments. This code has</td>
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	***Dementia C-SNPs Only**	an annual requirement, which may be satisfied by completing the Annual Wellness visit in WellAlign360, however for clinical groups who are not using this tool, this code must be billed annually either as a part of a rounding visit, annual wellness visit, or during any other billable encounter with a CPT code for an E and M visit. This code evaluates our CSNP memberships' current cognitive function and will be tracked across membership years to show progression of the severity of the member's dementia diagnosis. Appropriate interventions should also be documented within the progress note associated with the CPT code to include if appropriate institutionalization such as residence in a Long Term Care, Assisted living, or Memory Care facility that provides 24 hour care according to level of care and medical necessity. CMS rules and regulations pertaining to the billing of this CPT II code should be followed for claims adjudication purposes.

Note: For all other visits, document and bill all services provided as you would traditional Medicare.

SECTION 5: BILLING CLAIMS WITH MORE THAN 12 DIAGNOSES

During the Annual Wellness Visit process, many visits may capture greater than 12 diagnosis codes. Some EMR or billing tools used to submit claims may have a standard number of diagnosis codes submitted per visit or claims. It is important that the Plan is notified of ALL ICD-10 codes during those visits. The provider should validate initially, and ongoing, with their EMR/billing vendor that all ICD-10 codes are submitted to the Plan for each visit. See instructions below for submitting multiple claims for an encounter.

- Enter the CPT Code
- Units: 1 for each claim
- Amount: Enter contracted amount for the first claim
    - Add an additional penny per subsequent encounter submitted on members with more than 12+ diagnoses
    - Example: Jane Doe has 26 diagnoses
        - Claim #1: 1st set of 12 DX billed at contracted amount
        - Claim #2: 2nd set of 12 DX billed at $0.01
        - Claim #3: Last 2 DX billed at $0.02
- Continue the process until all claims are keyed/billed

Note: The Plan is set up to reimburse the provider for the first claim of 12 diagnoses based upon the contracted rate and will zero out the additional penny claims. The additional penny claims are still submitted to Medicare as Encounters for Risk Adjustment purposes. Remit will contain specific CARC/RARC information needed by the provider.

SECTION 6: FREQUENTLY ASKED QUESTIONS

1. Question: Can a Primary Care Provider (PCP) and Plan Provider visit the member on the same day?
   Answer: Yes, the PCP and Plan Provider do not compete for visits. The PCP will be able to bill the Plan for services/encounters and be paid for those visits, even if the Plan Provider also visits the member that day.

2. Question: Are there specific quality measures that our practice needs to send to AllyAlign Health (AAH)?
   Answer: The main requirement is the NP practice needs to submit claims to the Plan for services conducted for plan members. The quality measures AAH tracks are tied to the CPT/CPT II codes on the claims, so applicable submitted claims will "count" towards the submitting standard quality measures.

3. Question: Regarding CPT codes 99495-99496: Transitional Care Management, can we bill this when member goes from Hospital to SNF and PCP sees them there instead of office?
   Answer: Yes, PCP can bill this code when a member returns from the hospital to their LTC residence.