AllyAlign Health

FACILITY BILLING OVERVIEW

AllyAlign Health

AllyAlign Health

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

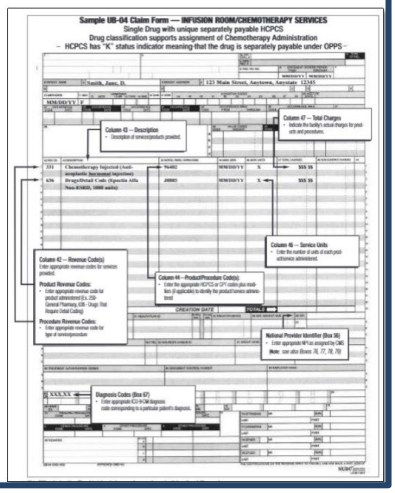
- The Plan follows all Medicare guidelines pertaining to timely filing requirements (12 months from date of service)
  - Cannot bill future date of service
  - The facility should bill the Plan as with Medicare, in 30-day increments

- Acceptable claim forms:
  - UB04 for Facility 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	Rural Health Clinics Center
Medicare MAC List	Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule
Ambulance Fee Schedule	Ambulatory Surgical Center (ASC) Payment
Anesthesiologists Center	ESRD (End Stage Renal Disease) Prospective Payment System
Clinical Lab Pricing Information	CMS Approved Telehealth Services- Audio Only Acceptable *COVID-19 Response
CMS Approved Telehealth Services *COVID-19 Response	

**Information subject to change by CMS*

SECTION 4: QUALITY MEASURES

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 OVERVIEW (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.

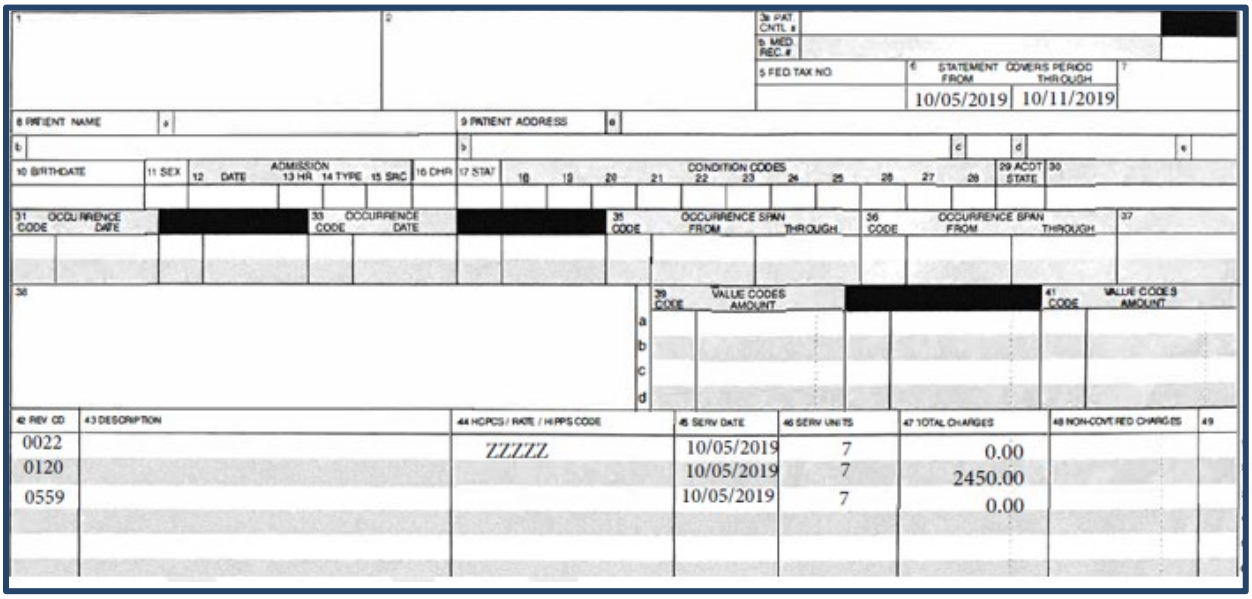
SECTION 5: SKILLED NURSING FACILITY BILLING

SKILL IN PLACE

- From and To dates should be the same at the Header and Detail lines.
- At a minimum, SIP claims should bill 3 lines with the following revenue codes 0022, 0120 and 0559 and include the quantity of days in SIP care.
- Total Charges are required. Amounts can be billed on any line, but will be priced on the first detail line of the Remittance Advice.
- Authorization is required.

Note: Please ensure to continue to bill with appropriate HIPPS codes.

- If your agreement/contract includes carve out services, please continue to bill those services separately.



42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022		ZZZZZ	10/05/2019	7	0.00		
0120			10/05/2019	7	2450.00		
0559			10/05/2019	7	0.00		

SKILL IN PLACE *WITH* DRUG BILLING REQUIREMENTS

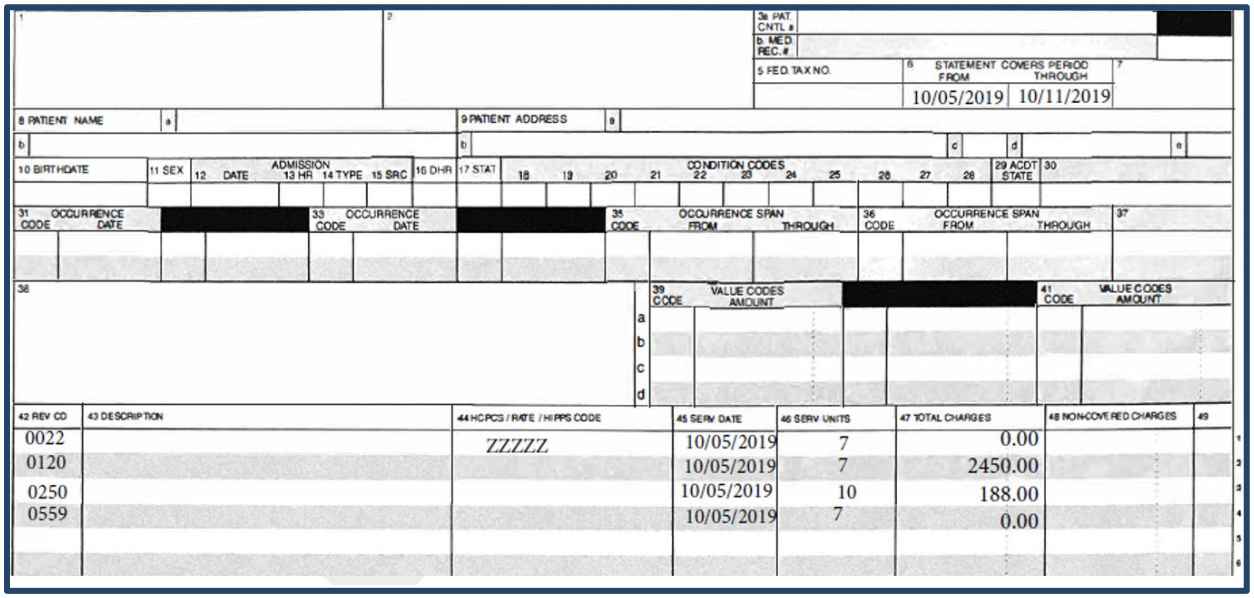
From and to dates should be the same at the Header and Detail lines.

Skill in Place Stay

- At a minimum, SIP claims should bill 3 lines with the following revenue codes 0022, 0120 and 0559 and include the qty of days in SIP care.
- Total Charges are required. Amounts can be billed on any line, but will be priced on the first detail line of the Remittance Advice,
- Authorization is required.
- Note: Please ensure to continue to bill with appropriate HIPPS codes.
- If your agreement/contract includes carve out services, please continue to bill those services separately.

Drugs

- Revenue code 0250.
- Pharmacy charges are to be billed on a separate line.
- Billed amount will be paid separately.
- Some medications may require authorization.



42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022		ZZZZZ	10/05/2019	7	0.00		
0120			10/05/2019	7	2450.00		
0250			10/05/2019	10	188.00		
0559			10/05/2019	7	0.00		

SECTION 6: 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 7: FREQUENTLY ASKED QUESTIONS

1. 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.