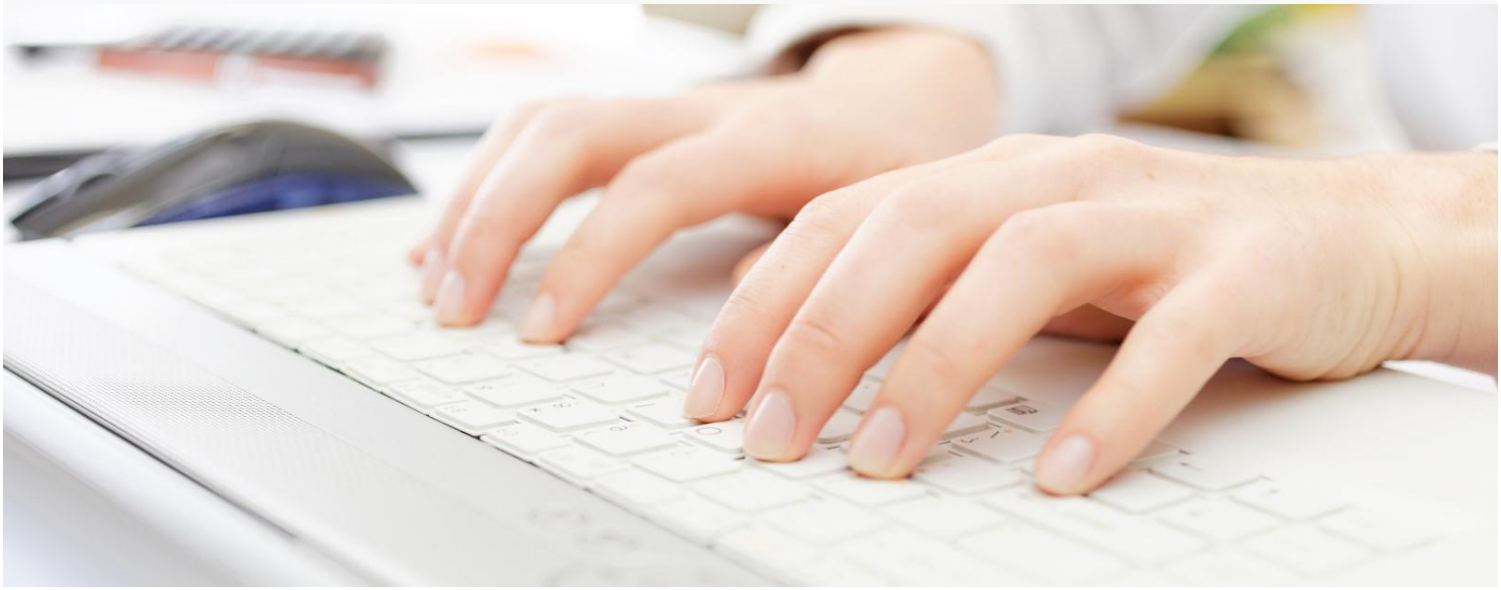
PointClickCare®



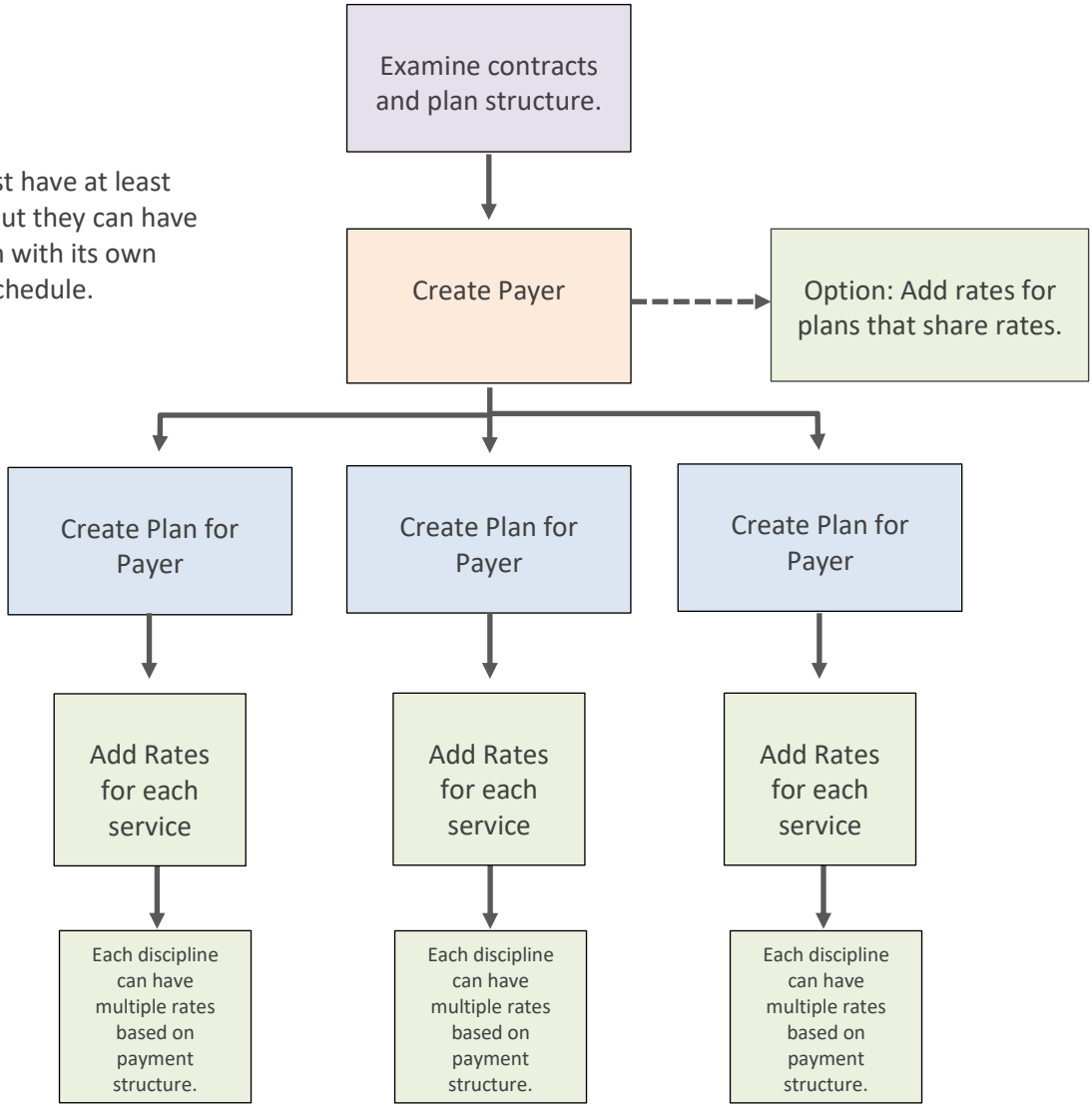
Session Guide:
Setting Up Payer Plans

After this session, billers and system administrators will be able to:

- Understand how Payer Plans are organized in the program
- Create payer plan setups
- Manage rates

Overview

Payers must have at least one plan, but they can have many, each with its own payment schedule.

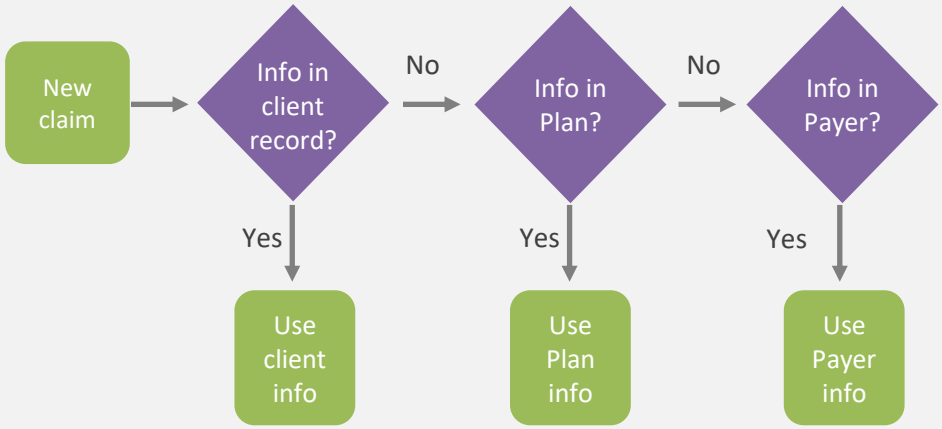


Understanding Payer/Plan Setup

Payers can have multiple Plans, all with different addresses, rates and billing requirements. However, they can also share addresses, rates and billing requirements. Maintaining this structure can become time consuming. Home Care's Payer/Plan specification lets you design a flexible Payer/Plan description that requires as little updating as possible.

How Home Care looks for Payer/Plan/Rate information

Before designing your Payer/Plan setup, it is important to understand how the Home Care program looks for billing information. When a new claim is generated, the system first looks for rate information in the client record. If none is found, it looks in the Plan setup. If information is not set up on the Plan level, the system looks for information on the Payer level.



What does this mean to you?

You can use Home Care's Payer/Plan lookup feature to simplify your Payer/Plan setup in many ways.

Example: Multiple plans, each with separate rates, one address

- Set up the address at the Payer level so that you only need to maintain it in one place.
- Set up rates and services on the Plan level.

This setup allows you to maintain the address in only one area, while specifying detailed rates for every plan.

Example: Four plans, one address, three plans share rates, one has separate rates

- Set up the address and the three identical rates/services on the Payer level.
- Set up the plan with separate rates/services on the Plan level.

This setup allows you to maintain the address and three identical rates in one area and specify only one separate set of rates for the fourth plan. For the standalone plan, the system finds rates on the Plan level before looking at the Payer level. For all other plans, the system finds no rates on the Plan level, so it uses the Payer level rates.

Prepare by Planning your Setup

Before beginning the Payer/Plan setup:

- Review your contract and know what your charge is per-discipline per-visit type.
- Understand all Plans included for a Payer. Every Payer must have at least one plan.

Think through how you will specify information for plans to create a setup that can be easily maintained.

Setting up a Payer

Procedure

1. With Admin privileges, go to **Administration > Payers.**
2. Click **Add Payer**.
3. Enter information in the **General** and **Billing** tabs. (If PointClickCare's EVV solution is supported in your state, setup is done by your PointClickCare Implementors.)

General tab

Enabled	Select to enable a Payer. Deselect to disable the Payer.
Name	(Required) Payer name.
Print Address on CMS 1500	Select to include the plan address on the CMS 1500 billing form.
Address	(Required) Enter Payer address. Note: Remember that the program gives first priority to an address listed for Plans included in the Payer. The first line (street address) and third line (City, State, Zip) are required. The

	second line is optional and can be used for extra identifiers, such as a suite number.
Phone 1, Phone 2	Enter Payer phone number(s) according to your agency's requirements.
Fax	Enter Payer fax number.
Website	Enter the Payer website.

Billing tab

Billing Frequency	Select how often your agency bills. Options are: • Daily – not recommended • Weekly – Sunday – Saturday • Biweekly - Sunday – Saturday • Semimonthly 1st and 15 of the month • Monthly 1st day of admission through end of month • Episodic 60 PDGM Cert period, NOA and 2 Finals • Episodic 30 – FFS based of cert period 1 final claim and no rap/noa The Billing Frequency determines when a new claim is created. For example, if you set the frequency to Daily, the system will create a new claim for each day a charge was generated.
Bundling of Charges	Select how charges are bundled for the Payer. Options are: **No Bundling** – All appointments are billed on their own individual service line. **Claim Level Bundling** – Appointments are billed together on a service line if they are for the same service on the same invoice. **Service Date Level Bundling** – Appointments are billed together on a service line if they are for the same service on the same day on the same invoice. **Appointment Level Bundling** – Bundle charges by appointments that have occurred for a given service, rev code, and modifier. **Appointment Level Crossdate Bundling** – Bundle charges by appointments that have occurred for a given service, rev code, and modifier. All appointments crossing over into the next day will be treated as one bundle for both days.

Electronic Payer ID	Clearinghouse payer list. Set up by your PointClickCare Implementor. This number pulls onto your 837 files when they are pulled into the Home Care system.
Use Default Billing Trading Partner	Set up by your PointClickCare Implementor.

4. Click **Accept**.

Setting Up Plans

Plan setup specifies how claims are billed. Keep in mind that you always need a Payer and at least one Plan, but you can create multiple Plans for a Payer and specify the rates/services in many ways. See Understanding Payer/Plan Setup.

Adding a New Plan

Use the following procedure when entering a new plan to a payer.

Tip: If you are adding a new plan that is similar to an existing plan, use the **Copy** function to make a duplicate of an existing plan that you can edit as necessary.

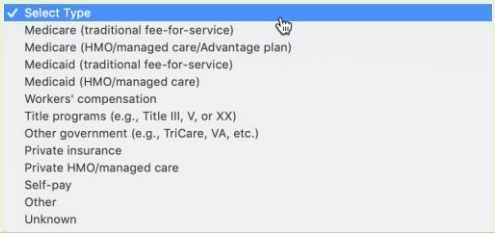
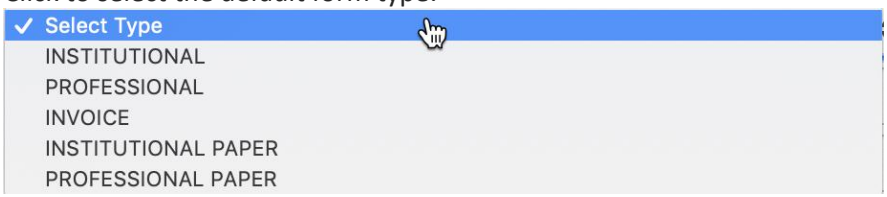
Procedure

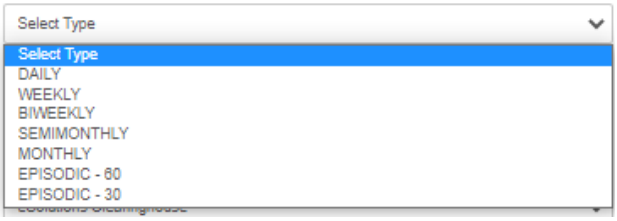
1. Go to **Administration > Payers** and for the Payer, click **Manage Plan**.
2. Click **Add Plan**.
3. Enter the Plan information:

General tab

Enabled	Click this selection to enable the plan.
Name	Name the plan according to your agency's procedures.
Use Payer Address	If the Plan uses the Payer address, select this option.
Address	Enter the Plan address. This field is disabled if the Use Payer Address option is selected

Billing Configuration

Type	Click to select from the type of billing configuration. 
GL Payer Plan Component	Include the portion of your GL account number that designates the payer for AR and Revenue. Note: General Ledger codes are set up by your PointClickCare specialist. Refer to your agency's codes or contact your PointClickCare specialist for assistance.
Bundle Charges	No Bundling – All appointments are billed on their own individual service lines. Claim Level Bundling – Appointments are billed together on a service line if they are for the same service on the same invoice. Service Level Bundling – Appointments are billed together on a service line if they are for the same service on the same day on the same invoice. Appointment Level Bundling – Bundle charges by appointments that have occurred for a given Service, Rev code and Modifier. Appointment Level Crossdate Bundling – Bundle charges by appointments that have occurred for a given Service, Rev code and modifier. All appointments crossing over into the next day will be treated as one bundle for both days.
Default Form Type	Click to select the default form type:  • Institutional/Professional will create electronic 837 file, • Invoice (statement) Institutional/Professional Paper will not create an 837 file

Electronic Eligibility ID	If the Electronic Eligibility ID differs from the one that was set up on the payer level, enter it here. If it is the same, leave blank. Every plan has an electronic eligibility ID assigned by our insurance eligibility partner, Dorado. PointClickCare distributes this spreadsheet and its updates periodically. Consult the list from Dorado or contact PointClickCare support. Electronic Eligibility ID.
Professional Epayer ID	If the Epayer ID differs from the one that was set up on the payer level, enter it here. If it is the same, leave blank. Most Clearinghouses have one ePayer ID per payer; however, there are instances where the Clearinghouse separates the EpayerID by Professional (CMS 1500) vs. Institutional (UB04) claims. If that is the case, they will assign you two separate EPayer IDs
Institutional EPayer ID	If the Institutional EPayer ID differs from the one that was set up on the payer level, enter it here. If it is the same, leave blank. Most Clearinghouses have one ePayer ID per payer; however, there are instances where the Clearinghouse separates the EpayerID by Professional (CMS 1500) vs. Institutional (UB04) claims. If that is the case, they will assign you two separate EPayer IDs.
Billing Frequency	Select how often your agency bills for this plan. The Billing Frequency determines when a new claim is created. For example, if you set the frequency to Daily, the system will create a new claim for each day a charge was generated.  • Daily – not recommended • Weekly – Sunday – Saturday • Biweekly - Sunday – Saturday • Semimonthly 1st and 15 of the month • Monthly 1st day of admission thru end of month • Episodic 60 PDGM Cert period NOA and 2 Finals • Episodic 30 – FFS based of cert period 1 final claim and no rap/noa

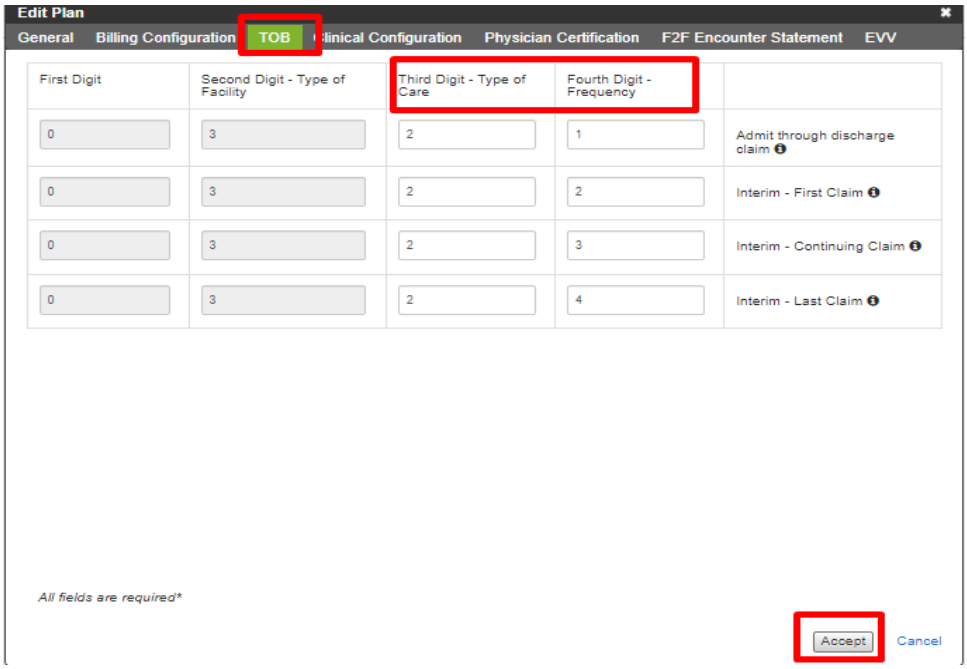
Reimbursement Type	Select whether the plan reimburses according to PDGM or fee for service. • FFS (Fee For Services) Daily, weekly, bi-weekly, semi-monthly, monthly and Episodic 30 • PDGM – Episodic 60 only (A Finals only option is available for Medicare Advantage plans, see configuration requirement below).
Medicare Reimbursement Percentage	Medicare advantage plans that reimburse a portion for PGPM and PPS payers. You can set a Medicare reimbursement percentage based on the contract's reimbursement amount. When the percentage is set up in the plan's billing configuration, the write-off adjusts automatically. This can also be utilized for traditional Medicare adjustments.
Medicare Reimbursement Percentage Effective Date	Enter the effective date of the plans reimbursement rate update. The system will keep track of previous rate updates.
Use Payer Billing Trading Partner	Use the Payer Billing Trading Partner field if it differs from what was set up on the payer level. If it is the same as payer, leave as is.
Billing Requirements	Select Billing options. • Automatically Create Authorizations – Service Orders will automatically create an authorization with the selected status. There are three options for auto-generated auths: 1. Auto-generate based on service order in a not required status so appts can be scheduled. 2. Auto-generate in a preliminary status so billing team gets alert when auth needs to be obtained from an insurance company. 3. Do not auto-generate auth, so auths for those insurances will always need to be manually entered to be able to schedule and bill for appts/services. • Co-Pay – Indicates a co-pay applies to the plan. • Preauthorization – For pending authorizations, when an appointment is marked as Reviewed, then the charges will be held until appointments are in compliance for this plan. • Service Description - Includes the Service Description on submitted claims for this plan.

	• Medicare details on the FFS claims (if set up as FFS for reimbursement type) • Claim ends on authorization date – ends claim based on the auth end date regardless of the billing frequency period (for FFS payers). • Completed Authorization (if set up as PDGM for reimbursement type) - Select Rap/Final/Lupa, RAP Only, or Final/Lupa only. • No-Pay Rap (if set up as PDGM for reimbursement type) • NOA Required – as of the effective date, RAP claims will no longer be created, and an NOA will be generated for each new case record • PDGM Finals Only – claims will follow the PDGM Finals workflow without the creation of an NOA or RAP. • Service Facility Location – will include the service facility location in the claim file.

TOB Set Up	Default configurations are set on the plan level that can be customized based on the payers needs for FFS in the TOB tab on the plan setup. *Note: Episodic 60 PDGM will auto default to 322/329.*

Type of Bill Configuration for FFS Only *(this will include changing Episodic 30 FFS plans to 329 if applicable).*

Note: Episodic 60 PDGM billing frequency/reimbursement type will auto default to 322/329.

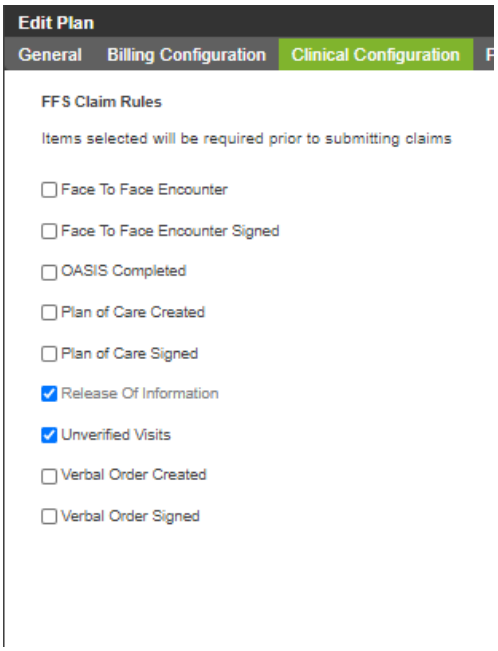


If changes are made prior to claims being created, the system will ***NOT*** retro the TOB. It will only apply to any new claims created after the changes have been made.

Clinical Configuration

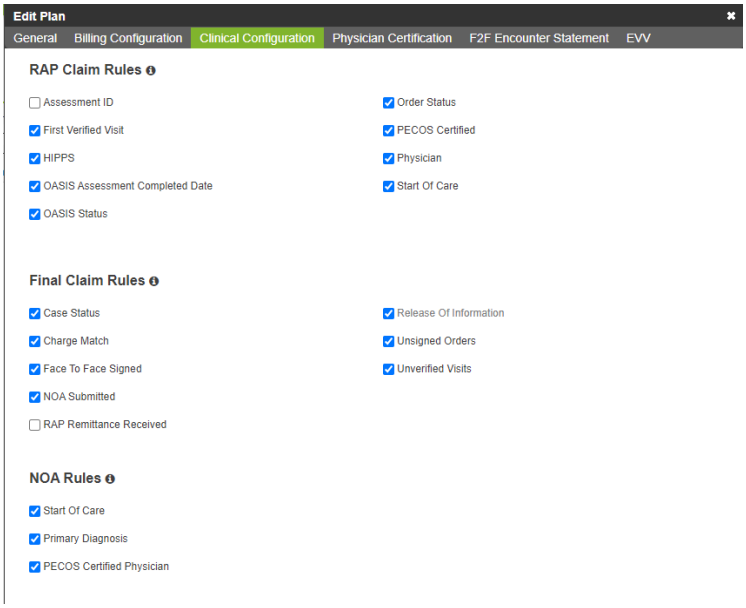
Select clinical items that are required for billing. This section is typically completed by your clinical specialist based on the agency's confirmation of the payer requirements. You can hover over each requirement to see what it does.

FFS type plan clinical requirements-
(Select based on the plan's clinical configuration)

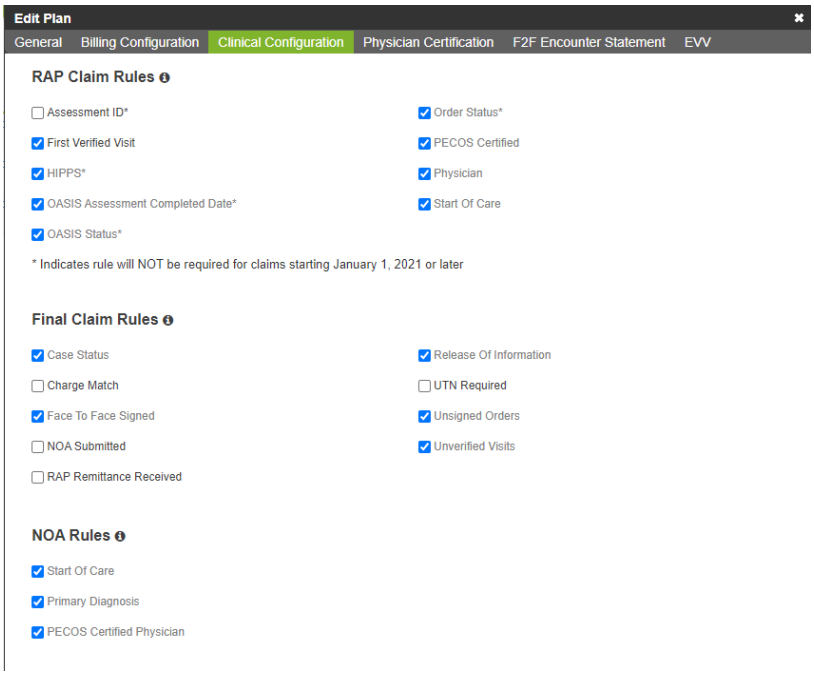


- Face to Face Encounter **OR** Face to Face Encounter Signed
- Oasis Completed
- Plan of Care Created **OR** Plan of Care signed
- Release of Information -*required for all plans*
- Unverified Visits
- Do ***NOT*** Select Verbal Order Created or Signed – *this is old functionality*

Medicare Advantage type plan clinical requirements-



Traditional Medicare type plan clinical requirements-



Physician Certification tab

Select the Physician Certification tab and configure options. Disable the statement, if necessary, by unchecking the Enabled box. Edit the Statement Message as required.

F2F Encounter Statement tab

Select the F2F Encounter tab and configure options. To disable the statement, uncheck Enabled for the state box. Create a state specific statement (you can multi-select states) and edit the Statement Message as required.

EVV

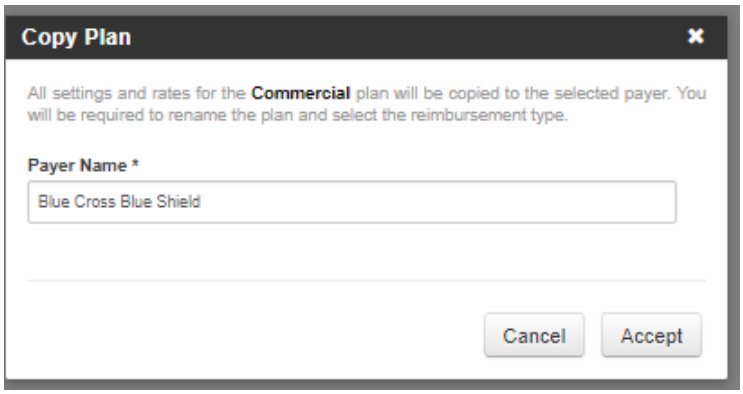
Configured by your PointClickCare Implementor.

Copying an Existing Plan

If you are adding a new plan that is similar to an existing plan, use the **Copy** function to make a duplicate of an existing plan that you can edit as necessary.

Procedure

1. Locate the Plan that you want to duplicate and click **Copy**.
2. Verify that you want to copy the plan and select the payer click **Accept**.



3. Name the copied plan and modify the configuration as required. See Adding a New Plan for details.

Managing Rates

You must enter Payer/Plan rates for every discipline that your agency offers. If you have a specific service for a discipline that pays differently (e.g. Start of Care), you will need to set a service-specific rate. You can manage rates at either the Payer or the Plan level. Keep in mind that you can use Home Care's Payer/Plan information lookup feature to design a rate description that requires as little maintenance as possible. See ***Understanding Payer/Plan Setup.***

As a general rule, if all plans pay differently, set your rates on the Plan level. If all plans pay the same rate, set up rates on the on the Payer level. If one or more plans pay differently, but several pay the same, you can set the rates up at the Payer level for Plans that share rates and set up rates on the Plan level for those that pay differently.

To set up services rates at the Payer level:

1. Go to **Administration > Payer.**
2. Select **Manage Rates** for the Payer.

To set up service rates at the Plan level:

1. Go to **Administration > Payer** and select the Plan.
2. For the Plan, select **Manage Rates**.

Adding Rates

You must add rates for every discipline that the plan covers. Some disciplines may have service-specific rates depending on your plan contract.

Procedure

1. Highlight the Plan and click **Add Rate**.
2. Enter the general rate information:

Branch	Select the agency branch. Used only if you have more than one branch. If the rates apply to all branches leave blank.
Effective Date/Expiration Date	Enter the dates in your contract. Monitor your contracts for these dates.
Service	If you have a service-specific rate, select the service. If the plan pays the same rate for the discipline regardless of the service performed, leave this field blank. Only use for service-specific exceptions.
Discipline	Select the discipline.
Rate Type	Select Hourly, Visit or Mileage according to your contract terms.
Taxonomy Code	Not required. This item is defined at the branch level and is configured by your implementor.
Unit Calculation Type	Select one of the following: **Time – Minimum First Unit** – Minimum amount of time the caregiver must be in the home to count as a full unit only. This only applies to the first unit. **This should rarely be selected!**

	Time – Minimum All Unit – Minimum amount of time the caregiver must be in the home to count as a full unit. Once the minimum unit is reached (e.g., 8 minutes out of a 15-minute unit) a charge will be generated. **Visit** – Unit value is applied to the visit. No matter how long the caregiver is in the home, the system will generate one visit on the claim.
Unit Scale	Not required.
Form Type	Not required. This item is defined at the Payer or Plan level. However, if the Form Type is selected here, it will over-ride what is set at the Plan or Payer level.

3. There can be multiple rates for the service/discipline broken out in many ways. Enter details in the rate table:

    a. Click **Add** to enter a new line in the rate table.

    b. Adjust the rate fields to describe the rate, for example the charge for the first half hour.

Rate Order	System assigned.
Rev Code	**Revenue codes** are three-digit **codes** that affect reimbursement and typically represent the discipline that provided the care. When **revenue codes** are listed on claim forms, they are listed with a leading zero, making them four digits. Enter the 4-digit revenue codes found on your contract.
Procedure Code	Procedure codes are five-digit codes that affect reimbursement and represent the services provided by the caregiver. Enter the procedure code from your contract.
Bill Rate	Enter your usual and customary rate. This will be the amount that will appear on the claim.
Reimburse Rate	Enter your expected reimbursement from this payer. This will be your contractual amount and will be used by the system for revenue recognition.
Unit Min	Enter the amount of time the caregiver must be in the home before a unit will be generated. (e.g., if the unit size is 15

	minutes but the caregiver must be in the home for at least 8 minutes before a charge can be generated, enter 8 in this field).
Unit Size	Enter the unit size in minutes (i.e. 15, 30, 60, etc.).
Rate End	Used when there is a modified or tiered rate. For example, if your agency charges one rate for the first unit, select End Rate to end the rate at that time. You can then enter additional rates for the next breakdown.
Modifiers (1-4)	Some charges require modifiers to indicate further information to the payer Follow your contractual guidelines for use of these fields.

c. Click **Add** to enter another rate.

d. Continue adding rates for all breakdowns in the pay rate for the service.

4. Click **Accept** when the Service Rate is complete.

5. Continue adding rates for all services.

Tip: *You can copy a rate and modify it for another service/discipline. For the Plan, select Manage Rates. Click **Copy Rate** and modify as required.*

Importing Payer Rates

You can import rates from another payer. This is helpful for payers with similar rates, saving you time and improving accuracy.

1. Select **Payer** > **Manage Rates**

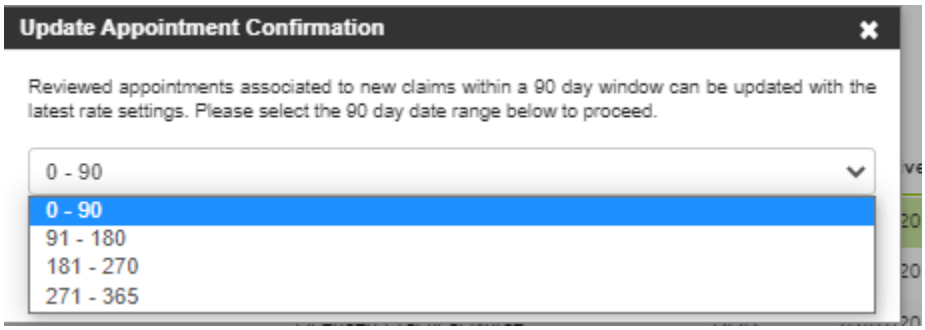
2. Import Rates

3. Select Payer Name of the rates you would like to import.

Editing Rates

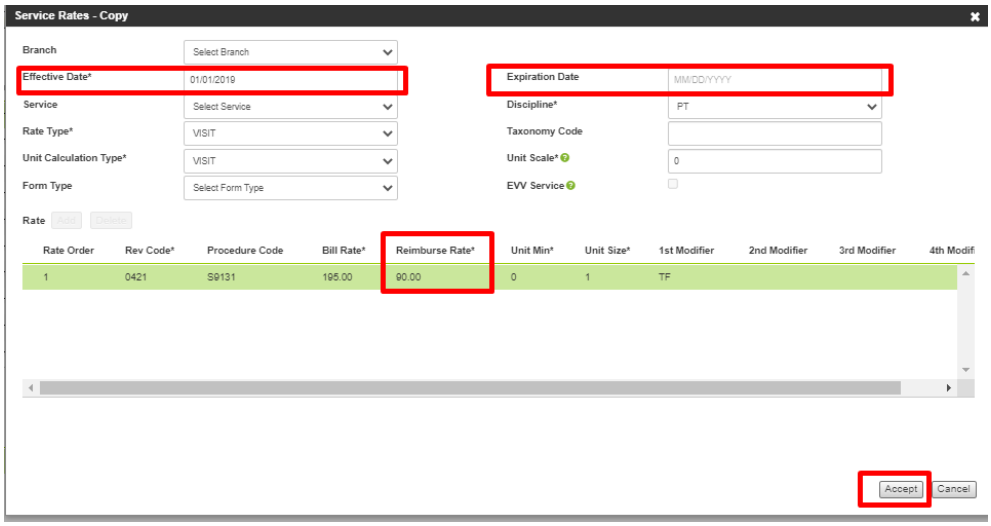
To edit an existing rate, click **Edit**. Change fields as required and click **Accept**.

Apply Rate Update *Note: will only apply to claims that are in* ***New Status***



Rate Changes

1. Edit, enter Expiration Date and Accept.
2. Click on Copy, change Effective Date and remove the Expiration Date, update the Reimbursement Rate and Accept.



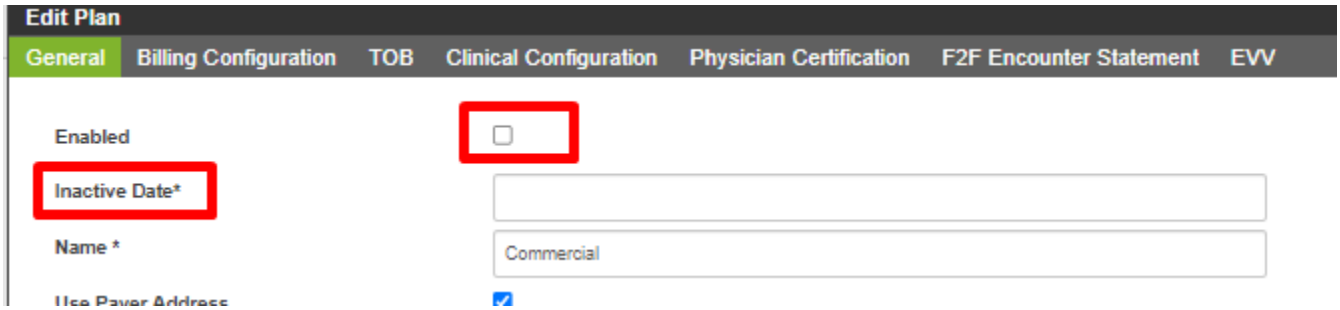
Payer/Plan Inactive Date

In Payers, an Inactive Date field is added in the payer and plan levels. You can define and track when a payer or plan becomes inactive.

After you clear Active, select the Inactive Date. Clicking Accept also updates the Coverage End Date in the Patient Plan. If you inactivate the payer, all plans are updated with the inactive date. If you activate the payer again, you must manually reactivate applicable plans. If you activate the payer or plan again, you can manually edit the Coverage End Date, if needed.

Enabled Payer Level

Enabled Plan Level



Notes: