2013

ISAS Reference Guide for Exceptions, Billing and Adjustments

Agency Providers

Note: Accurate as of December 12, 2013. Future guidance will supersede instructions.

Maryland Department of Health and Mental Hygiene
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Contents

ISAS Background Information

The In-house Support Assurance System (ISAS) will enable the Maryland Department of Health and Mental Hygiene (DHMH) to monitor the delivery of in-home personal care services. ISAS ensures that these services are provided as outlined in the recipient's Plan of Care (POC) and by an authorized service provider.

To access the ISAS phone system providers dial a toll-free number, and enter their credentials; upon successful credential authorization the service start time and end time are recorded. The ISAS phone system authenticates service delivery providers using an Integrated Voice Response (IVR) system and/or a One-Time Password (OTP) device.

- **Integrated Voice Response (IVR)** – During the initial enrollment process the provider is asked to speak a phrase into the phone system. The IVR application uses an algorithm to create a sound bite of the provider's voice and stores that sound bite for verification purposes. Each time the provider performs a service call they speak the same phrase initially provided at registration. The IVR application then matches the sound bite created during the service delivery against the sound bite created during initial enrollment. Assuming the sound bites match, the provider is authenticated.

- **One Time Password (OTP)** – In most cases the phone verification system verifies the client based on the phone number assigned to the landline where the service call is initiated. In circumstances where a landline is not available, patients are issued an OTP device. An OTP device is a time synchronized device used to authenticate the time that a service takes place. It is a keychain sized device kept in the client's home. The device has a serial number that is assigned to individual clients. The front of the device displays a randomly generated six-digit number. This randomly generated number changes every 60 seconds and can be traced back to a specific date and time, which in turn, is used to authenticate the service provided.

In addition to the phone verification system, ISAS also interacts with the Maryland Medical Information System (MMIS) and the Long Term Services and Support (LTSS) system. Interaction with MMIS authenticates both provider and client eligibility through daily batch file transfers of Provider Enrollment, Recipient Eligibility, and Service Rate files. Interaction with LTSS is strictly for verification of a clients' Plan of Service or Plan of Care (POS/POC), and ensures that the most recent recipient and provider information is validated.

Exceptions Overview

What is an Exception?

An exception is created when a call transaction and the resulting service activity cannot be validated. There are nine reasons that service activity cannot be validated:

1. *Missing Clock In*
2. *Missing Clock Out*
3. *Provider Type / Client Program Mismatch*
4. *Provider Not on Client POS*
5. *Multiple Services*
6. *Client Ineligible*
7. *Client not Enrolled in Waiver Program*
8. *No Active POS*
9. *Clients POS does not have ISAS services*

These exceptions are handled by DHMH.

The purpose of the next section is to provide an overview of the nine exceptions and how they are triggered.

Exception Types

DHMH ISAS Staff

Exceptions Handled Exclusively by ISAS Staff:

1. ***Missing Clock Out–*** The triggers for this exception include:
    a. Provider clocked in for service but never clocked out; OR
    b. Provider clocked in for service but the clock out occurs over 14 hours from the time that the provider clocked in for the same service.
2. ***Missing Clock In –*** The triggers for this exception include:
    a. Provider clocked out for service but never clocked in; OR
    b. Provider clocked out for service but the clock in occurs over 14 hours prior to the time that the provider clocked out.
3. ***14 Hour Exception***
    a. Any shift that exceeds 14 hours automatically triggers a missing clock in/out exception (i.e. times beyond 14 hours are not linked). DHMH reviews shifts exceeding 14 hours prior to payment.
4. ***Provider Type / Client Program Mismatch –*** The triggers for this exception include:
    a. Client is enrolled in the Living at Home Waiver (LAH) program but the provider clocked in or out with an Older Adults Waiver (WOA) provider number;
    b. Client is enrolled in the Older Adults Waiver (WOA) program but the provider clocked in or out with a Living at Home Waiver (LAH) provider number;
    c. NOTE: ISAS will treat clients enrolled in ICS the same as those enrolled in LAH.
5. ***Provider Not on Client POC –*** The trigger for this exception includes:
    a. The client is enrolled in a waiver program, has an active POC with a billable ISAS service, but the provider is not assigned to the ISAS service on the POC
6. ***Multiple Services –*** The trigger for this exception includes:
    a. The client has the same provider giving 'Agency Provider (with meds)' and 'Agency Provider (without meds)' services.

DHMH Waiver Program Staff

Exceptions Handled Exclusively by Program Staff:

7. ***Client Ineligible –*** The trigger for this exceptions includes:
    a. A client is deemed ineligible by the MMIS verification process (Screen 1 or Screen 8 issues).
8. ***No Active POC –*** The trigger for this exception includes:
    a. Client is enrolled in a waiver program but has no active POC.
9. ***Client not Enrolled in Waiver Program –*** The trigger for this exception includes:
    a. Client's enrollment status is not equal to "Enrolled"; OR
    b. No enrollment status is assigned to the client.
10. ***Clients POC does not have ISAS services –*** The trigger for this exception includes:
    a. The client is enrolled in a waiver program, has an active POS, but no billable ISAS services are listed on the POS.

Q. What is the easiest way to view claims by staff provider?

A. Claims are submitted at an Agency / Client level, not at an Agency / Staff / Client level. Meaning that all services provided by your staff to a given individual will be grouped into one claim for the purposes of billing. This is to ensure that the correct number of billing units, based on rounding rules applied to 15 minute services, are processed and sent to MMIS for payment.

As an administrator you have access to three Claims reports, accessible by selecting the Reports tab after you log into ISAS and then by clicking the View link associated with the Claims reports. Once the Claims report loads you will have access to three different views of this report:

- ***Staff Claim Summary*** – This report provides a summary of services provided by each of your staff for the timeframe specified within the report input parameters. Specifically it lists the name of each staff that provided services within that timeframe, the number of services provided within that timeframe, the number of billable units associated with those services, the total amount billed to MMIS for those services provided, and the amount that MMIS will pay for those services. Please see screenshot below.

ISAS - Claims Report

Staff Claim Summary

Total Number of Records Returned: 3669

Provider Name	Staff Name	Program	Service	# Services Provided	# Billable Units	Total Billed Amount	Total Paid Amount
Agency Name	Staff Provider	LAH	W4000 - Attendant Care (Agency Provider)	11	402	$1719.5550	$1415.8525
	Staff Provider	LAH	W4000 - Attendant Care (Agency Provider)	14	224	$958.1600	$615.9600
	Staff Provider	LAH	W4000 - Attendant Care (Agency Provider)	28	476	$2036.0900	$1758.0525

- ***Claim Detail*** – This report provides a listing of each claim that has been sent to MMIS on behalf of your agency for the timeframe specified within the report input parameters. Specifically this report lists for each claim generated and sent to MMIS for processing the individual receiving the service, the type of service provided, the number of units billed for the service provided, the total amount billed to MMIS, the date the service was provided, the date the claim was sent to MMIS for processing, and the current status of the claim.

- ***Staff Claim Detail*** – This report is similar to the Claim Detail report in that it provides information regarding each claim sent to MMIS. The main difference is that it includes staff level information. Specifically this report lists the date the service was provided, the name of the individual receiving services, the amount

sent to MMIS for services provided to the individual, the amount that MMIS will pay for the service, the name of the staff providing services to the client on that day, the length of time each staff was with the client providing services, the number of billable units for each staff based on duration of service, and the total billable amount for that staff for services provided. Please see screenshot below.

Date Created: 11/20/2013 11:55:21 PM

ISAS - Claims Report

Staff Claim Detail

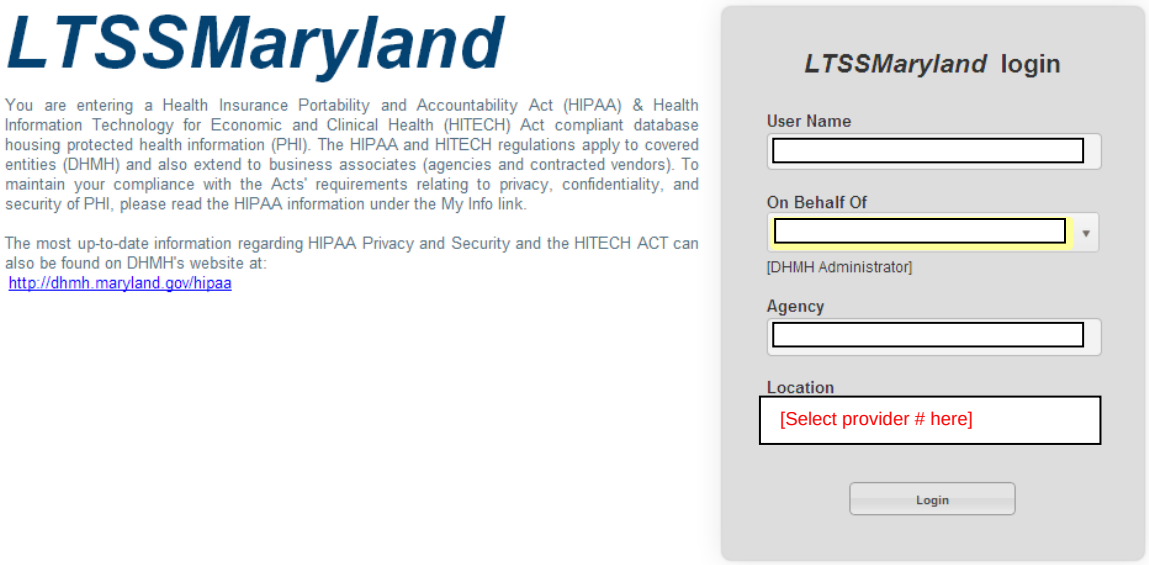
Total Number of Records Returned: 36972

Claim Date	Claim Type	Service Date	Provider Name	Client Name	Program	Service	Total Billed Amount	Total Paid Amount	Staff Name	Staff Minutes Of Service	Staff Billable Units	Staff Billable Amount
11/7/2013	Original	11/6/2013	Agency Name	[redacted]	LAH	W4000 - Attendant Care (Agency Provider)	$183.9325	$183.93(	Staff Provider	246	16	$68.4400
									Staff Provider	130	9	$38.4975
									Staff Provider	262	17	$72.7175

Q. What if the hours seem different from what the provider believes they have worked?

A. It is likely that an exception is preventing the claim from being submitted for billing.

To check if an exception is preventing your claims from being submitted, you need to login to ISAS. When you login, you will see the following screen.



Please note that the Location dropdown field is your provider number. If you have multiple provider numbers then all provider numbers will be listed in that dropdown.

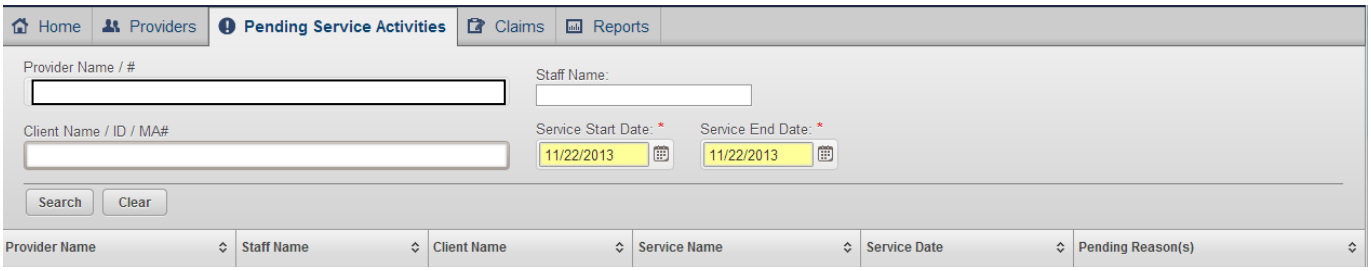
Agencies with one provider number:

- You will only see one provider number listed.

Agencies with multiple provider numbers:

- The number that is selected as the location will correspond to the claims and pending service activities associated with that number.
- If you need to see information associated with your other provider number you will need to return to this page and select that provider number from the Location dropdown.

After you select the correct provider number, click on the 'Pending Service Activities' tab in ISAS. You will see the following screen.



When you search by staff name or client name, all associated exceptions will appear. Below are all exception types, definitions, and their estimated resolution times.

1. ***Client Program and Provider Type Mismatch***

   Problem: Provider number does not match the program in which client is enrolled. For example, if the client receives LAH services and the staff accidentally entered the WOA provider number rather than the LAH provider number.

   Resolution: ISAS staff will contact waiver program staff and resolve. **NO** action needed by agency provider.

   Estimated Resolution Time: **48 hours**

2. ***Provider not on Client POS***

   Problem: Provider is not listed on participant's plan of service (POS).

   Resolution: ISAS staff will contact waiver program staff and resolve. **NO** action by agency provider needed.

   Estimated Resolution Time: **48 hours**

3. ***Multiple Services***

   (Specific only to WOA participants)

   Problem: Currently no option exists for a WOA provider to select personal care without medical administration (W0202) or personal care with medical administration (W0203), when calling ISAS.

   Resolution: ISAS staff reviews POS to determine on which days participant receives W0202 and W0203 then resolves exception. **NO** action needed by agency provider.

   Estimated Resolution Time: **48 hours**

4. ***Missing Clock-In or Missing Clock-Out***

   Problem: Missing clock-in or clock-out.

Resolution: Agency Administrators **MUST do three things:**

a. View the Pending Service Activities tab and note the staff provider, date of service, and whether the missing time is a clock out or clock in.
b. Contact the staff provider and tell them the date of service, whether a clock out or clock in is missing and ask the provider to call the Help Desk.
c. **Remember:** Even after the staff provider calls the Help Desk, the missing time will remain in the Pending Service Activities tab until the 10 business days expires and the situation is completely resolved.

Estimated Resolution Time: **10 business days**

General Information on Missing Clock in/Missing Clock out

When Help Desk would enter missing clock in or out:

Provider calls Help Desk at 4:30 pm because they forgot to clock out at 4:15 pm. Help Desk would enter 4:15 pm clock out time for the provider and that claim would be processed overnight, as usual.

*When Help Desk would **NOT** enter missing clock in out:*

Provider calls Help Desk at 7 pm because they forgot to clock out at 5:30 pm. Help Desk would NOT enter the time into the system. Instead Help Desk would log the clock out and pass the information to DHMH for extensive review.

5. ***Client Ineligible***

Problem: Participant is ineligible to receive service.

Resolution: ISAS staff will contact waiver program staff and case managers to correct. Agencies will not have to do anything unless asked.

Estimated Resolution Time: **7-10 business days**

6. ***No Active POS***

Problem: Participant's plan of service (POS) has expired.

Resolution: ISAS staff will contact waiver program staff and case managers to resolve. NO action needed by agency provider.

Estimated Resolution Time: **7-10 business days**

7. ***Client Not Enrolled in Waiver Program***

Problem: Participant is not currently enrolled for waiver services.

Resolution: ISAS staff will contact waiver program staff and case managers to correct. NO action needed by agency provider.

Estimated Resolution Time: **7-10 business days**

Note: All exceptions remain on the Pending Service Activities tab until they have been completely resolved.

Q. Why is the paid amount of the claim different than what should have been billed?

A. Administrators may request adjustments in the system. This will require an explanation as to why the hours appear to be different. Adjustment requests may only be made for claims that have a "paid" or "rejected" status. (A claim with any other status, other than paid or rejected may not be adjusted)

Q. Why are reports and claims only viewable from Oct. 3rd for LAH services and Nov. 7th for OAW services?

A. ISAS started billing for LAH services on October 3, 2013 at 12:00 AM. Meaning that a claim will be generated for any service provided by your staff with a clock in time greater than or equal to 12:00 AM on October 3. Similarly, ISAS started billing for WOA services on November 7, 2013 at 12:00 AM. Meaning that a claim will be generated for any service provided by your staff with a clock in time greater than or equal to 12:00 AM on November 7. The Claims report only provides you with information regarding claims that have been generated via ISAS. All claims that were sent via other methods prior to this date and time will not be available within ISAS.

In short, reports for LAH claims with a date of service prior to October 3, 2013 are **NOT** available. Claims prior to October 3 will be based on submission of paper time sheets. Reports for WOA claims with a date of service prior to November 7th will **NOT** be available. Claims prior to November 7th will be based on submission of paper time sheets.

Q. Which report should we check regularly so we can avoid claims issues?

A. The services rendered report will be very useful to view daily. It will show all services provided by your staff on a given day, and the status of those services. The various statuses that you may see associated with a service are as follows:

- Ready – A record with this status means that the service has passed all verifications performed by the system and is awaiting claim generation. Claims are generated every morning between the hours of 2 AM and 6 AM. So, any service with this status will be processed the next day.

- Pending – A record with this status means that the service has failed one or more of the verifications performed by the system (e.g., missing clock in or clock our, etc…) and is on hold pending review by DHMH. Once DHMH completes their review this status will be updated.

- Closed – A record with this status means that a claim has been generated and sent to MMIS for processing and payment for this service.

Q. Who is the best person to contact regarding additional billing/adjustments questions?

A. For technical questions that relate to using ISAS to request adjustments or view claims, contact the Help Desk at 855-463-5877. For questions that relate to billing policy, contact John Wilson at john.wilson@maryland.gov or 410-767-1719.

Q. Can we request adjustments for older claims?

A. If the claim is for an LAH service and has a date of service **prior to** October 3, 2013, OR if the claim is for an OAW service and has a date of service **prior to** November 7, 2013 contact the following:

WOA: Contact Linda Smith at LindaL.smith@maryland.gov.

LAH: Email Lamont Freeman at Lamont.freeman@maryland.gov

If the claims have a date of service on **OR** after October 3, 2013 for LAH services, **OR** a date of service on **OR** after November 7, 2013 for OAW services, requests can be made within ISAS. Please refer to the two-page tutorial on Claims and Adjustments either on the ISAS home page. If you have further questions, please contact the Help Desk at 855-463-5877.

Q. What do agency administrators have to do to submit claims?

A. Agency administrators no longer have to submit claims. When a provider clocks in and clocks out, assuming an exception is not generated for the service, a claim is automatically created and sent to MMIS daily, and adjudicated weekly.

Q. Will our agency banking information carry over from the eMedicaid or the previous paper billing?

A. Yes.