

FAQs: Billing

1. When can my organization submit a claim? Do I have to wait for the authorization window to end?

Providers can submit a claim only after the service is complete. Tenancy Services has a 30-day unit of service, so providers must wait until the 30-day billing cycle is complete before they can submit a claim.

The provider does not have to wait for the authorization window to close.

- For example, if the authorization window for Tenancy Services is from January 1 to June 30 and the current date is March 15th:
 - o The provider may submit claims for the first two billing cycles (i.e., January 1-30 and January 31 – March 1).
 - o The provider may not yet submit a claim for the current billing cycles or future billing cycles.

2. How do I know which fields on the CMS-1500 billing form are required? Is there any guidance available to help with claims submission?

Please refer to DMAHS' [CMS-1500 billing guidance](#). The instructions include step-by-step directions on how to fill out the billing form.

3. What should I do if my claim was denied but service was authorized?

We recommend connecting with your MCO to determine the reason for claim denial and then resubmitting your claim. Many claims denials are due to administrative errors (e.g., entering the incorrect dates of service) and MCOs are best positioned to troubleshoot any errors.

4. My claim was denied. Does the denial cause my authorization to end early?

No, claim denials do not cause an authorization to end early. As a reminder, providers can work with their MCO to correct and resubmit their claims.

5. I was unable to satisfy the face-to-face touchpoint requirement during the 30-day authorization window for Tenancy services. Can I still submit a claim for payment if I met with the member virtually?

No, at least half of the required minimum number of touchpoints for a level of need must be in-person with a member (e.g., for a low level of need member, 1 out of the minimum 2 touchpoints must be face-to-face).

6. I am working with a member who is authorized for a higher level of need. I was unable to meet with the member four times over a 30-day period, but I was able to meet with them twice. Am I still allowed to submit a claim?

Yes. If your member is authorized for services for a higher level of need but you are only able to meet 2 touchpoints (the amount sufficient for a member with a low level of need), you may submit a claim. However, you may only bill for the lower level of need service rate. This is referred to as “step down billing.” If this is your situation, the modifier you enter on the Procedure Code portion of the CMS-1500 billing form will differ from the modifier on your authorization form. We recommend contacting your MCO with any further questions.

7. I am working with a dual eligible member who was authorized for services. When my organization submitted a claim, it was denied by Medicare. Do I need to do anything to receive approval from Medicaid?

If a member is dual eligible and uses the same MCO for both Medicare and Medicaid, the claim will first be denied by Medicare as part of MCO standard operating procedures. However, the claim will next automatically flow to Medicaid for approval. There is nothing the provider needs to do to ensure the claim flows to Medicaid after being denied by Medicare. In other words, a denial from Medicare does not mean the claim was also denied by Medicaid.

8. How does each MCO accept claims submissions?

Each MCO accepts claims submission slightly differently. See below a recap of how each MCO accepts claims submissions. Please note that specific contact information can be found in the Initial Assessment Tool and in the provider guidance on Camden Coalition’s [website](#).

- **Horizon**

- *Out-of-network providers*: Accepts email, mail, and fax submissions
- *In-network providers*: All of the above, plus access to Availity

- **UHC**

- *Out-of-network providers*: Accepts email, mail, and fax submissions
- *In-network providers*: All of the above, plus access to UHC portal

- **Fidelis**

- *Out-of-network providers*: Accepts email, mail, fax, and Availity
- *In-network providers*: All of the above

- **Aetna**

- *Out-of-network providers*: Accepts email, mail, and fax submissions
- *In-network providers*: All of the above, plus access to Availity

- **Wellpoint**

- *Out-of-network providers*: Submissions only through Availity
- *In-network providers*: Same as above (only through Availity)