PROMISe™ Billing Quick Reference Document
For ODP RESIDENTIAL Services
(Eligible and Ineligible)
Informational Packet # 015-09

PURPOSE: This Office of Developmental Programs (ODP) Informational packet is a Quick Reference provider resource which summarizes the ODP billing processes and rules associated with ODP eligible and ineligible Residential services effective July 1, 2009.

Since implementation of the new prospective payment system on July 1, 2009, ODP has been monitoring and analyzing provider billing actions and looking at repeated claim denials, suspended claims, and inquiries made to the ODP Claims Resolution inquiry phone lines and email box.

As recurring billing-related problem areas are identified, Quick Reference resources are being developed and issued to the ODP provider community. ODP’s goal is to supply providers with useful training resources to better equip you for independent self resolution activities as they pertain to your claim denials and suspends.

The attached Informational Packet # 015-09 titled, “PROMISe™ Billing Quick Reference for ODP Residential Services (Eligible and Ineligible)”, addresses frequently asked billing questions for Residential Habilitation services that will serve to provide billing clarification.

Discussions are currently in process, within DPW, regarding Room and Board for Waiver-Funded Residential services. When decisions have been finalized, another communication will be issued at that time.

If you find you are unable to resolve your billing or claim issues, please contact ODP Claim’s Resolution Section at:

e-mail: ra-odpclaimsres@state.pa.us
Phone: 1-866-386-8880 Mon – Thurs 8:30-12:00 and 1:00 - 3:30
BILLING RULES For Eligible and Ineligible Residential Services

**Billing Rules for Eligible and Ineligible Waiver-Funded Residential Services**

**Rule #1:** For eligible and ineligible Waiver-Funded Residential services, the “From” and “To” dates on the claim detail line (service line) should always equal the units (days) indicated on the same claim detail line. For example, if you enter “07 01 2009 – 07 03 2009” in the “DATES OF SERVICE (DOS)” block on your claim, then the “UNITS” block should equal 3 (day units). **If the “DATES OF SERVICE” do not match the number of billed units entered on the claim for Waiver-Funded Residential services, then the claim detail line will deny.** View Informational Packet #014-09 for resolution procedures related to error status code (ESC) 772.

**Rule #2:** For ineligible and eligible Waiver-Funded Residential services, the “From” and “To” dates on the claim detail line **should not span (overlap) calendar months.** Monthly spanning occurs when a claim is billed with dates of service that includes more than 1 calendar month on a claim detail line (service line) or more than 1 calendar month is on the entire claim across multiple claim detail lines (service lines). View Informational Packet #014-09 for resolution procedures related to ESC 774.

**Billing Rules for Ineligible Waiver-Funded Residential Services**

**Rule #1:** Make sure you follow the rules above.

**Rule #2:** Ineligible Waiver-Funded Residential services must be billed in the month that follows the month in which the service was rendered. **If you bill before the following or subsequent month after the service is rendered, then your claim detail line containing the ineligible Waiver-Funded Residential procedure code will be denied.** View Informational Packet #014-09 for resolution procedures related to ESC 773.

**Rule #3:** The provider’s charges to the individual for Room and Board must be included in the appropriate field on the claim transaction when billing for ineligible Waiver-Funded Residential Services. **A zero dollar amount or a blank space will result in a claim denial.** View Informational Packet #014-09 for resolution procedures related to ESC 778.

**Note:** Rules #2 and #3 directly above only apply to the ineligible portion of an authorized Consolidated and Person/Family Directed Support (P/FDS) Waiver service. The billing frequency for Ineligible Base service claims, billed through PROMISe™, is at the discretion of your County Program.
FAQs for Billing the Ineligible Portion of Waiver-Funded Residential Services

Why do I have to include the individual’s Room and Board contribution on my claim when I am billing for the ineligible portion of Waiver-Funded Residential Services?

The fiscal year 2009-2010 rate for the ineligible portion of Waiver-Funded Residential services is a gross rate. In order for the claim’s processing system to calculate the net rate due to the provider from ODP, the amount entered on the claim for the individual’s Room and Board contribution is used to reduce the total gross claim payment amount to a net payment amount.

Why do I have to wait until at least the first day of the subsequent month after the service was rendered in order to bill for the ineligible costs for Waiver-Funded Residential services?

There are two reasons why the provider is asked to wait to submit a claim for payment until the subsequent month after the ineligible service is rendered:

1. Federal and state regulations require that services are rendered before a provider is permitted to submit a claim to the state requesting payment.

2. Although the ineligible Waiver-Funded Residential service is a day rate, the individual’s Room and Board contribution is reported monthly on the claim submission.

What if the individual receives other income such as personal income from Inheritance, Pennsylvania State Supplemental Payments, SSA, Railroad Retirement, VA Benefits, earned income or other types of income? How do I account for this income in the appropriate field on the claim?

Regardless of the individual’s income sources, the provider shall assess the individual for his Room and Board contribution according to the Standard Room and Board Contract as specified in 55 Pa Code § 6200.35, not to exceed 72% of the SSI maximum rate. In other words, the individual should not be charged any more than 72% of the monthly SSI maximum rate for Room and Board. The provider can obtain the individual’s Room and Board contribution from any of the income sources listed above but the amount charged to the individual should not exceed 72% of the monthly maximum SSI.
FAQs for Billing Ineligible Portion of Waiver-Funded Residential Services (con’t)

How do I bill for the ineligible Waiver-Funded Residential service when the individual moves from residence A to residence B in the middle of a calendar month?

When the individual moves in the middle of a calendar month, pro-rate the Individual’s Room and Board monthly contribution and enter the amount in the appropriate “Patient Pay” field on the claim. For instance, an individual lives in residence A from 7/1 – 7/27 and moves to residence B from 7/28-7/31. Divide the total monthly Room and Board charges by 31 days. If the total monthly charges to the individual for Room and Board is $500, then for the date span 7/1 – 7/27, the amount in the “Patient Pay” field on the claim would equal $435.24 ($16.12 X 27 days). For the date span 7/28 – 7/31, the amount in the “Patient Pay” field on the claim would equal $64.48.

When I bill for the ineligible portion of Waiver-Funded Residential services, do I have to bill for the entire month on one claim?

Yes and no. If the ineligible Waiver-Funded Residential service was rendered to the individual for the entire calendar month, you should indicate this on the claim detail line. In addition, enter the amount charged to the individual as their Room and Board contribution in the appropriate “Patient Pay” field on the claim.

If the service was rendered only part of the month, then enter the dates of service and day units to reflect the partial month. The amount charged to the Individual for Room and Board for the partial month should be entered in the appropriate field on the claim and be calculated as per Pa Code Chapter 6200. See the example on the next page for the amount to enter as the individual’s Room and Board contribution.
I provide services to an individual who receives rent rebate and the rent rebate amount is deducted from the Room and Board costs. Do I have to account for rent rebate on the claim transaction?

Yes. When the provider receives the rent rebate check, the total amount for the period of a year, starting from the calendar month the check is received, should be pro-rated. Add the pro-rated monthly rent rebate amount to the individual’s Room and Board monthly charges and indicate the total amount in the appropriate “Patient Pay” field on the claim. For example, if rent rebate is $360, divide the $360 by 12 calendar months, which equals $30 per calendar month. If the individual’s Room and Board monthly contribution is $450, then the amount that should be entered in the appropriate “Patient Pay” field on the claim would equal $480 ($450 + $30). If the pro-rated monthly rent rebate amount contains 3 decimal places, please round down to the second decimal place. For example, $25.228/month should be rounded to $25.22/month.

If an individual moves during the year and the provider has already received the rent rebate for the year, then the provider should add the remaining rent rebate balance to the final claim submission for that individual. For example, the provider collected the rent rebate in July 2009 for $650.00. The individual moves into a nursing home on November 1, 2009. The provider should add $50.17 to the individual’s monthly Room and Board contribution amount on each claim for dates of service in July, August, and September 2009. When the provider submits the ineligible Waiver-Funded Residential service in November 2009 for dates of service in October 2009, the remaining rent rebate balance for the year should be added to the individual’s monthly Room and Board contribution amount which is then entered into the appropriate “Patient Pay” field on the claim.

**Individual moves after rent rebate has already been collected by the provider**

July, August, & September 2009 pro-rated monthly amount: \[ 50.17 \times 3 = 150.51 \]

Balance of rent rebate: \[ 650 - 150.51 = 499.49 \]

**Amount to enter in “Patient Pay” field on claim:**

$499.49 + individual’s monthly Room and Board contribution
FAQs for Billing Ineligible Waiver-Funded Residential Services (con’t)

What if the individual’s Room and Board contribution is greater than the total PROMISe™ calculated allowed amount?

If the individual’s Room and Board contribution is greater than the total PROMISe™ calculated allowed amount, then PROMISe™ will pay the claim detail line (service line) for the ineligible portion of the residential service at “zero”. Although DPW is not issuing a payment for the ineligible service when the PROMISe™ calculated allowed amount is less than the room and board amount, ODP encourages providers to submit claims for the ineligible portion for 2 reasons:

1. The first reason for submitting the ineligible portion of the Waiver-Funded Residential service is that when a provider audit is conducted by the federal or state government, your billing transactions for the ineligible portion of the Residential Service will be consistent with your organization’s record-keeping, thus ensuring compliance with existing federal and state regulations.

2. Second, the day units for the ineligible portion of Therapeutic Leave for Waiver-Funded Residential Services are counted to determine when the 48 day fiscal year limitation has been exceeded. The day-units for the ineligible portion of Medical Leave Waiver-Funded Residential Services are counted to determine when ODP is to reduce its payment from 100% to 60% of the ineligible Waiver-Funded Residential rate.

Below is an example of how PROMISe™ calculates the payment for the ineligible portion of Waiver-Funded Residential services. When billing for the ineligible portion of Waiver-Funded Residential services, enter the individual’s Room and Board contribution in the appropriate field on the claim.

Actual Room and Board Cost (Ineligible Residential Service) $1,000.00 (fictitious)

Provider charges to Individual for Room and Board Less: $485.28 (72% of $674)

The total PROMISe™ calculated reimbursed amount $514.72

Note: The monthly maximum Federal SSI amount for calendar year 2009 is $674.00 for an eligible individual. Each calendar year the maximum Federal SSI amount changes.
FAQ For Billing the Eligible Portion of Waiver-Funded Residential Services

When do I bill the Eligible portion of Waiver-Funded Residential procedure codes?

The eligible portion of Residential Habilitation services may be billed anytime after the service has been rendered (such as daily, weekly, or monthly): Please remember that payments are only made once a week for claims submitted successfully (also referred to as “clean claims”).

Note: For more detail regarding the payment cycle, please view ODP Webcast, titled “Managing for Successful Billing”. Three (3) billing webcasts are available to support the new prospective cost-based system. These webcasts are located on odpconsulting.net. Once you reach the odpconsulting.net home page, go to the left hand side of the screen and scroll down until you see the link titled “ODP Webcasts”.

In addition, under webcasts, there is also a link, titled “Managing for Successful Billing Handouts”. that contains 10 CMS 1500 claim examples, as well as other handouts that pertain to the billing webcasts. After clicking on the link mentioned above, left click on the link titled “ODP Managing for Successful Billing Part #1 Handouts”. The paper claim examples are contained in the file titled “CMS1500 Scenarios.pdf.”
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**Billing for BED RESERVATION Days (Therapeutic and Medical Leave)**

**Rule #1:** When billing for Medical Leave and Therapeutic Leave, you must follow the same rules for Residential Services that are stated on the previous page. Therapeutic and Medical Leave apply to Residential Services and, therefore, would follow the same rules. The *Place of Service* (POS) code entered on the claim for either Therapeutic or Medical Leave should be the same POS code used for the Residential service.

**Rule #2:** If billing for either Medical Leave (UD) or Therapeutic Leave (UC) for the eligible or ineligible portion of the Residential Habilitation Waiver service, **only enter one** Residential Habilitation waiver procedure code plus modifier on the claim. Do not add a second claim detail line with the same Residential Service procedure code, dates of service, and units minus the modifier. Payment is only made for providing the service to the individual **or** when the individual is on Medical Leave or Therapeutic Leave, **but not both**. Below is the bottom portion of a CMS 1500 Professional paper claim form demonstrating the rule.

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### NOT PERMITTED TO BILL

Claim line #1 below. This scenario is considered billing twice for a service that was only rendered once because the “Dates of Service”, procedure codes, and units are all the same on the two claim detail lines (Service lines). Claim detail line 2 is the eligible portion of the Residential Habilitation Waiver service with a Medical Leave modifier; therefore, line one should be removed from this claim and **only** line 2 and 3 below should be billed. The same billing rule applies to Therapeutic Leave.  

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**Signature**

Date

For more information on modifiers, please view Informational Packet 011-09, titled, “Informational Packet 011-09 ODP Modifiers”, found on [http://www.odpconsulting.net](http://www.odpconsulting.net)

For current ODP resources, please visit [odpconsulting.net](http://odpconsulting.net)
BILLING FAQS FOR BED RESERVATION DAYS (THERAPEUTIC & MEDICAL LEAVE)

How should you bill when you anticipate exceeding Federal Funding Participation (FFP) day limits for the fiscal year for the eligible and ineligible portions of Bed Reservation Days?

- There is a 30-day limit on Federal match funds, also known as FFP, for Bed Reservation Days.
- Bed Reservation day units are accumulated for both the eligible and ineligible portions of Medical and Therapeutic Leave individually and together.
- When either the accumulated combination is greater than 30 days, or when the individual accumulated amount for either the eligible or ineligible portions of Medical Leave or Therapeutic Leave is greater than 30 days, the Federal Funding Participation ends and the State pays for the units submitted in excess of 30 days for the eligible and ineligible portion of Bed Reservation Days. State funds are paid at 100% for the eligible portion and 60% for the ineligible portion after FFP ends.
- In order for the system to pay the claim using the correct funding source, any units billed in excess of 30 day units must be billed on a separate claim detail line (service line) or separate claim at the point where units go from 30 to 31 units or more.

After the funding source has officially changed and been recognized by PROMISE™, any additional units submitted during the State Fiscal Year for either Therapeutic Leave or Medical Leave eligible or ineligible Waiver Services can be billed as they were before the 30 unit limitation was exceeded.

What if you exceed the Federal Funding Participation day limits within the fiscal year for the eligible and ineligible portion of Bed Reservation Days and do not realize it when you bill?

When a claim for either the eligible or ineligible portion of Therapeutic Leave or Medical Leave is billed and the date span is 31 days or more (for example: 07/01/09 – 07/31/09 = 31 units), PROMISE™ will modify the claim detail end date of service and the number of units will reflect 30 days allowed. The provider will need to bill the 31st and subsequent days on a separate claim in order to receive payment.

Do I have to include the ineligible portion of Therapeutic or Medical Leave on the same claim as the ineligible Residential service?

Although PROMISE™ does not prevent you from submitting multiple ineligible Waiver-Funded Residential claims for dates of service that fall within the same calendar month, all ineligible services rendered within the same calendar month should be billed together on one claim (the same claim). This will ensure the individual’s charges for Room and Board are applied properly to your PROMISE™ calculated reimbursed amount.

What amount do I enter as the individual’s Room and Board contribution when the individual is on Medical or Therapeutic Leave during the month?

Assuming the ineligible Residential service and the ineligible portion of Medical or Therapeutic Leave are billed on the same claim, as is strongly recommended, enter the total amount charged to the individual for Room and Board for the calendar month in the appropriate “Patient Pay” field on the claim. If the individual was charged for 15 days worth of Room and Board, then that amount should be entered in the “Patient Pay” field.
**Scenario:** This claim covers the ineligible portion of a three-individual, Chapter 6400 licensed community home from 7/1/2009-7/31/2009. The ineligible Residential Habilitation rate of the home is $10.00 per day unit. From 7/11/2009-7/20/2009 the individual goes to visit his family on Therapeutic leave (UC). While at his family's home, he suffers an injury and requires hospitalization. From 7/21/2009-7/31/2009 the individual is on Medical leave (UD).

### Signature Exception

**Date:** 08012009

**NIHIQI:**

**Identification:**

**Date of Current:**

**Diagnosis or Nature of Illness or Injury:**

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**Note:** All ineligible Residential Habilitation Waiver services must be billed, at the earliest, in the subsequent month after the service was rendered. This includes Ineligible Residential Services with Therapeutic and Medical Leave modifiers.

**Note:** The consumer contribution to Room and Board costs should be entered in box 29 under "Amount Paid". This amount should reflect the dollar amount the provider charges to the individual for Room and Board.
How does the Provider find out if they have been authorized to bill for a Permanent Vacancy?

Once you have submitted a request to your ODP Waiver Capacity Manager and have been approved for a Permanent Vacancy by ODP, ODP sends out a notice to each provider which indicates whether approval for a Permanent Vacancy has been PROMISe™ authorized. If you did not receive an ODP notice regarding your Permanent Vacancy request, please contact your Regional Waiver Capacity Manager.

Once you have been PROMISe™ authorized to bill for a Permanent Vacancy, the following billing rules apply:

Rule # 1: Enter the PROMISe™ authorization number in the appropriate field on the claim when billing for a Permanent Vacancy. ODP PROMISe™ authorization, not to be confused with HCSIS authorization, is required for each unplanned Permanent Vacancy. If approval has been PROMISe™ authorized for a Permanent Vacancy, the ODP notice sent to you will contain the number of units authorized, dates of service in which the authorization is valid and a PROMISe™ authorization number. You are required to enter the PROMISe™ authorization number on your claim submission in order to receive payment.

If the system finds a Permanent Vacancy procedure code(s) on your claim and does not find a valid PROMISe™ authorization number in the appropriate field on the claim, your claim will deny.

The PROMISe™ authorization number should be entered into the “Prior Authorization Number” field which is available on each of the different claim transaction methods (CMS1500, PROMISe™ Internet, Provider Electronic Solution Software (PES) or third party billing software).

Rule # 2: In general, the service or services that have been issued a PROMISe™ authorization number are the only service or services permitted to be billed on one single claim. In other words, only the unplanned Permanent Vacancy codes for the eligible and ineligible components are permitted on one single claim (procedure codes W7056 and W7030). No other service detail lines unrelated to the PROMISe™ authorization number, in this case Permanent Vacancy, are permitted on the claim with the PROMISe™ authorized services.

If you enter any other service on the claim other than the Permanent Vacancy codes, the claim detail line(s) for those service(s) will deny and the Permanent Vacancy services will pay.
Billing for PERMANENT VACANCIES (con’t)

Rule # 3: The provider must enter the Recipient Identification Number on the claim, also known as the RID, of the individual who vacated the residential setting in order to receive payment for the Permanent Vacancy. **If the correct RID is not found on your claim, then the claim will deny.**

Please Note: If a PROMISE™ authorized Permanent Vacancy is submitted on a claim for an individual whose eligibility was end-dated on the Department’s eligibility system (CIS), then the claim will deny and set error status codes (ESCs) 2003 and 4021. ODP is currently working to resolve this issue. Please contact the ODP Claim’s Resolution Section if your claim denied for this reason at:

- e-mail: ra-odpclaimsres@state.pa.us
- Phone: 1-866-386-8880 Mon - Thurs 8:30-12:00 and 1:00 - 3:30
FAQs for Billing Permanent Vacancies and Respite

Who do I contact if I am interested in rendering Respite services during a Permanent Vacancy?

If during a Permanent Vacancy a residential provider decides to temporarily use the unplanned Permanent Vacancy for respite, then the provider should contact their ODP Regional Waiver Capacity Manager. This step is important because the Permanent Vacancy PROMISE™ authorization will need to be temporarily end-dated so the Respite service can be billed successfully.

What happens to the PROMISE™ authorization once I agree to render Respite service during Permanent Vacancy?

The Regional Waiver Capacity Manager will end date the authorization for the Permanent Vacancy with an end date that is equal to the first day the Respite service is rendered.

What will happen to the days I have accumulated for the Permanent Vacancy once I agree to render Respite services during a Permanent Vacancy?

The days for the Permanent Vacancy will stop accumulating the first day that the Respite service is provided during the unplanned Permanent Vacancy.

! NOTE: Do not attempt to bill for the Permanent Vacancy after the ODP Waiver Capacity Manager has approved and processed your request to render Respite services during the Permanent Vacancy. If you attempt to do so, your claim will deny.

What will happen once you have completed rendering Respite services and now want to bill once again for a Permanent Vacancy?

It is important you contact your Regional Waiver Capacity Manager when you have completed rendering Respite services and now would like to begin billing for the Permanent Vacancy once again. The Waiver Capacity Manager will reactivate your PROMISE™ authorization number and modify the dates of service on the PROMISE™ authorization to reflect a new start and end date. If the PROMISE™ authorization is not reactivated and you decide to bill for a Permanent Vacancy, an edit will post and the claim detail line for the Permanent Vacancy will deny.

Once the Permanent Vacancy is re-authorized in PROMISE™, the units will begin accumulating again for the Permanent Vacancy. The unit accumulation for Permanent Vacancy will resume from the point that the Respite service was end dated.

For current ODP resources, please visit odpconsulting.net
FAQs for Billing Respite Services During a Temporary Absence

What if I would like to provide Respite Services during a temporary absence?

Respite is permitted in a residential setting during a temporary absence. DPW calculates payment to the provider for Respite during a temporary absence based on a combined rate. The Respite rate is a combination of the eligible and ineligible portions of the Residential Habilitation service established for the specific residential service location in which the Respite service is being provided and billed.

The provider is not permitted to bill both Respite and Residential services for the same individual and the same dates of service.

What if the amount of respite services anticipated will result in exceeding the fiscal year unit limitation for either 15-minute or 24-hour Respite services?

Although the individual’s ISP may contain approved units for Respite in excess of the fiscal year unit limitation, this does not guarantee that PROMISe™ will approve the Respite claim for payment if the system determines the fiscal year unit limitation has been exceeded.

If, after a team discussion has taken place, it is anticipated that the fiscal year unit limitation for either 15-minute or 24-hour Respite services may be exceeded, a “REQUEST FOR EXCEPTION TO ESTABLISHED SERVICE LIMITS OR MAXIMUM NUMBER OF SERVICE UNITS” form must be completed (DP1023) by the SCO. The SCO will submit the completed DP1023 form to the appropriate Administrative Entity (AE). The AE will review the request and forward it to their ODP Regional Program Manager (RPM), who will review it and approve or disapprove the request.

The ODP Claim’s Resolution Section must have the approval for the exception on file before a claim with excess units is approved for payment. When a claim is submitted that contains either 15-minute or 24-hour Respite units in excess of the fiscal year limitation, the entire claim will suspend. ODP Claim’s Resolution staff will conduct a manual review of the suspended claim, determine if an approval is on file, and make a determination whether to pay the excess units submitted on the claim or deny the excess units submitted.

Do not render or bill for Respite services that are in excess of the fiscal year limitation until ODP makes a determination on the request for additional respite services specified on Form DP 1023.