Mobile Caregiver+

NE Specific - Mobile Caregiver+ Claims Console Quick Reference Guide

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**** This Quick Reference Guide does NOT replace solution training. Those assigned to the Provider Administrator or Biller role will have access to all features of the Mobile Caregiver+ Claims Console. A Provider Administrator or Biller is anyone that manages completed visits and/or claims.*

*Please review policies and procedures set by Payers before completing the Claims process. A Provider Administrator or Biller should follow the set guidelines of a Payer. ****

Mobile Caregiver+ Claims Console Overview

After a visit has been completed, the Provider Administrator has the ability to review, adjust and electronically release the visit as a claim to the Payer via the Work List screen in the Provider Portal.

- If a Provider uses the Mobile Caregiver+ Solution, the Mobile Caregiver+ Claims Console will automatically process and transfer service records to the Work List for Claims Processing. Providers can use the Visits list to troubleshoot missing service records. If successfully transferred to the Work List, the system will display "**SUCCESS**" in the Visits to Claims status field in the Visits option of the Main Menu.
- If a Provider is using an **Alternate EVV System**, Providers must complete the **ready-to-bill** process (send visit data to their Mobile Caregiver+ Provider Portals for claims processing) before the Mobile Caregiver+ Claims Console will process and transfer billable service records to the Work List.

*****Service records that are successfully processed for completed visits will be transferred to the Work List, where they will be screened using Payer defined pre-adjudication rules. *****

Three potential Work List statuses:

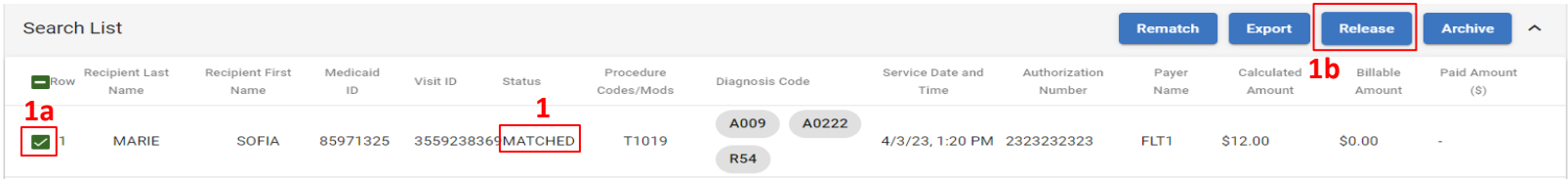
1. **New** – Service records that are initially transferred to the Work List or service records that were just edited or updated.
2. **Matched** – Service records that have been screened and are following the defined Payer rules; Matched service records do not have reported errors and can be released for remittance. Only Matched service records can be released for claims submission.
3. **Unmatched** – Service records that have been screened and are not in line with the defined Payer rules; Unmatched service records have reported errors that must be remediated and rescreened to change the status to Matched.

In the **Work List**, a Provider Administrator can click on the service record to expand and view the visit details. Any field in the Work List with the pencil icon can be edited or adjusted to reflect billable visit data if the actual visit data is inaccurate. All fields labeled as '**Actual**,' is visit data recorded by a mobile device and cannot be adjusted. **Any adjusted 'Billable' values will always override 'Actual' values and will be sent for claims submission**. Provider Administrators are required to select Reason Codes to provide explanations for changing rendered service data.

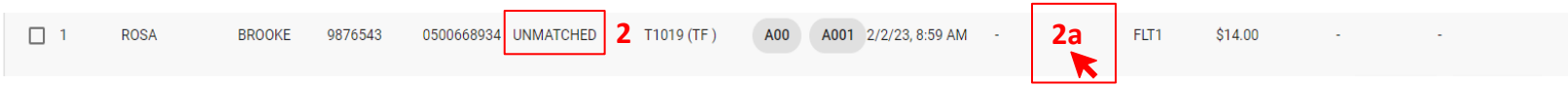
Only Matched service records can be released for claims submission. For all Unmatched service records, Providers MUST fix all reported errors to change the status to Matched before releasing for claims submission. Follow the steps below for Matched and Unmatched service records.

1. For service records in the status of '**Matched**':
    a. Select the visit checkbox.

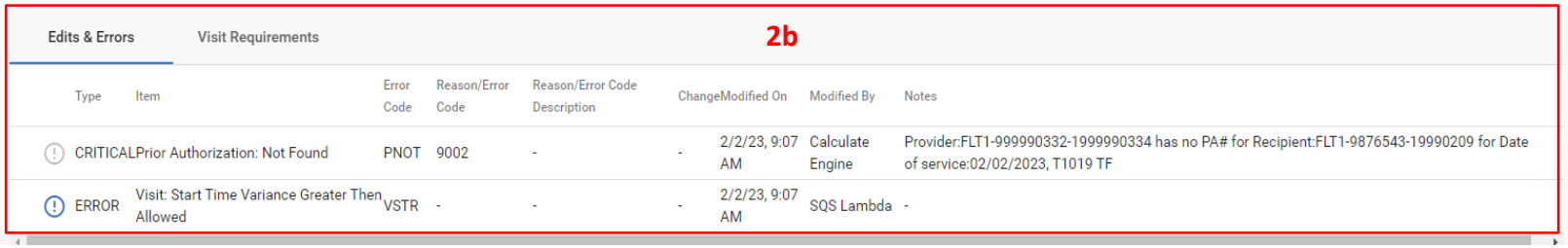
b. Select '**Release**'.
c. The visit will be released to the Payer and the status can be reviewed in **Claim Review**. The status will change to '**Released**'.



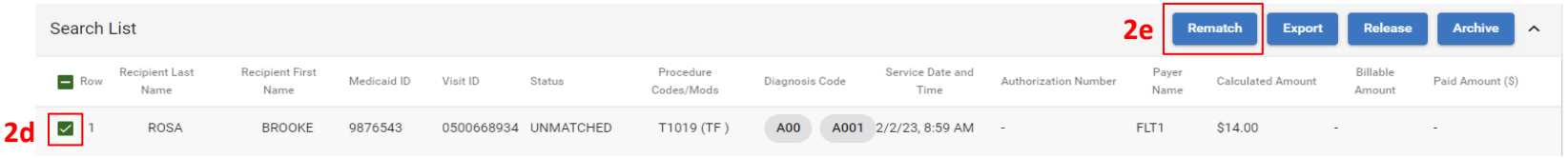
2. For service records in the status of '**Unmatched**':
   a. Click on the Unmatched service record to open it.



   b. Scroll to the bottom of the service record, to the **Edits and Errors Report** error.



   c. Remediate and clear all the reported errors. Refer to the **How to Clear Reported Errors in the Work List** section of this document.
   d. Once all reported errors have been resolved, select the visit checkbox.
   e. Select '**Rematch'**.



   f. Rematching a service record will screen the service record against the Payer's set rules again. Once rematched, the visit Status should reflect '**Matched**' and can be released to claims submission.

Claim status after being released from the Work List can be monitored on the **Claim Review** screen. *Voids and Adjustments to claims can also be done in Claim Review.*

Service Records displayed in Claim Review will have one of nine statuses:

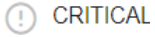
1. **Released** – Billable service records that have been released from the Work List but have not yet been submitted to the Payer.
2. **Submitted** – Billable service records that have been submitted to the Payer.
3. **Accepted** – Billable services that have been accepted by the Payer, which are then considered as claims to be reviewed for adjudication. Claims that are accepted by the Payers are assigned Internal Control Numbers (ICN) to be used for identification.
4. **Rejected** – Billable services that have technical errors, such as incorrect or missing data will be labeled as "Rejected;" Rejected service records are returned to the Mobile Caregiver+ Work List for remediation.
5. **Denied** – Claims that the Payer accepted, reviewed, and adjudicated to deny (refuse) payment for. Claims may be denied for untimely submission, duplicate claim submission, etc.
6. **Paid** – Claims that the Payer accepted, reviewed, and adjudicated to remit the full amount.
7. **Paid Partial** – Claims that the payer accepted, reviewed, and adjudicated to remit partial payment for. Providers may choose to adjust partially paid claims.
8. **Adjusted** – Paid or Partially Paid claims that a Provider has edited (made changes to, and resubmitted for adjudication).
9. **Voided** – Paid or Partially Paid claims for which a Provider has voided (reversed) payment.

How to Clear Reported Errors

For all **Unmatched** service records, Providers MUST remediate all reported errors to change the status to Matched. There are two types of rules the Provider Administrator could encounter in the Work List:

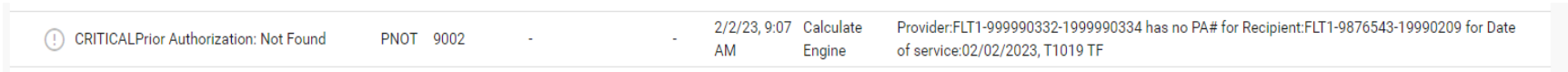
Please review the MCG+ Claims Console User Guide for step-by-step instructions on how to clear each error.

1. **ERROR** – Can be cleared with a reason code. Error appears blue and can be clicked on to display a dialogue box with available reasons to clear the error. *** Some of these errors must be cleared by first adjusting data within the Service Record and then clearing the error message. ***

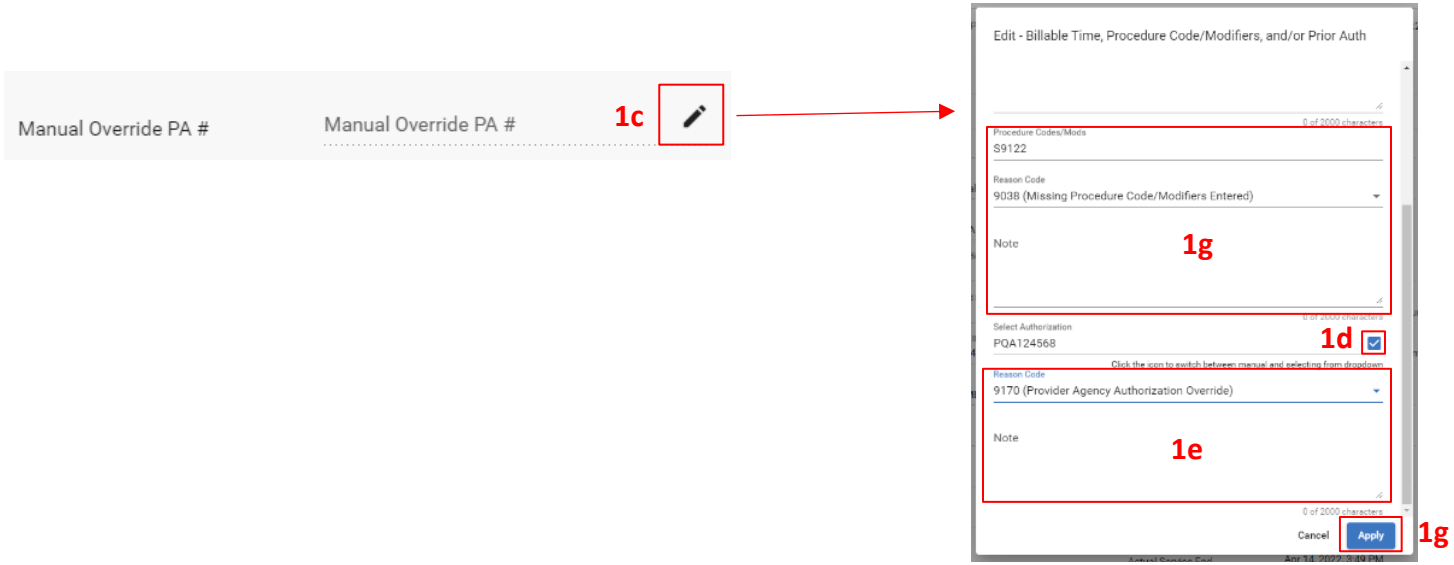
2. **CRITICAL** – Can only be cleared with a visit data change/update within the service record. The error appears gray and is unable to be clicked on. This rule type must be cleared by adding to or adjusting visit data within the service record, to meet the minimum requirement by the Payer. 

The following instructions show how to clear a **CRITICAL** and **ERROR** message.

1. **PNOT – Prior Authorization: Not Found**
   a. The PNOT error message indicates that no valid authorization was found for the Recipient based on the Procedure Code/Mods listed in the service record.



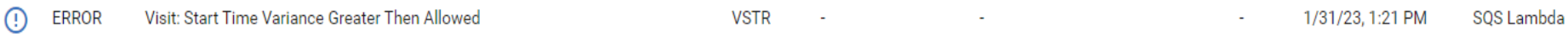
   b. As it is marked as a **CRITICAL** error, the visit data within the record needs to be cleared. To clear the PNOT error requires the active Authorization on file for the member and service code, to be attached to the selected service record.
   c. Select the pencil icon next to the '**Manual Override PA#**' field to open the *Edit – Billable Time, Procedure Code/Modifiers, and/or Prior Auth* dialogue box.



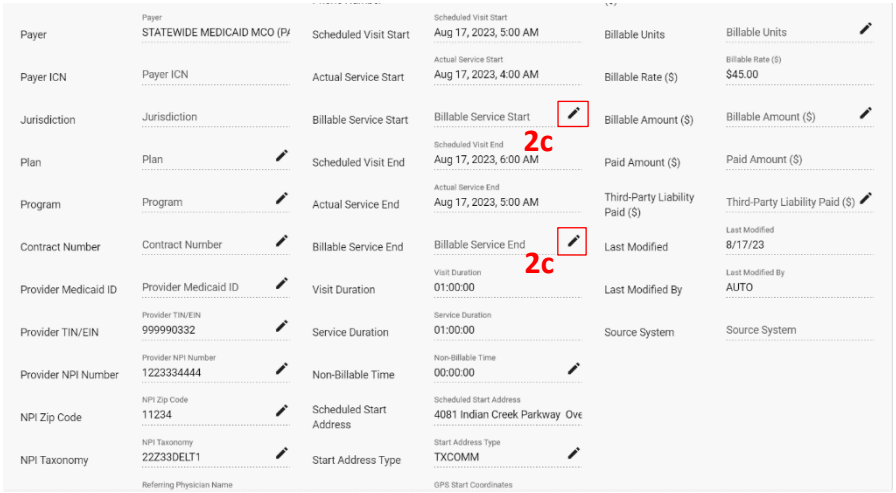
   d. Select the checkbox next the '**Select Authorization'** field to display authorizations on file for the member and select the authorization for services.
   e. Select the '**Reason Code'** to provide an explanation for the change and enter a **Note** if applicable.

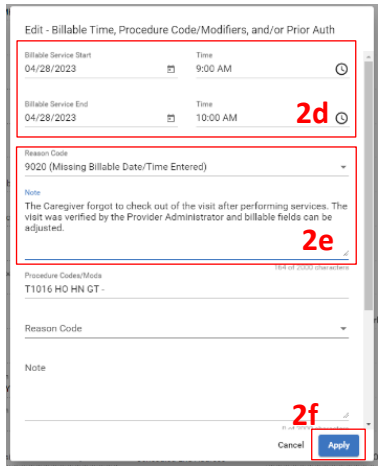
f. Verify the **Procedure Code** is the correct code that is attached to the selected Authorization. If not, use that field to update the Service Code and provide a reason and note for updating the field.
g. Click '**Apply'** to clear the CRITICAL error.

2. **VSTR – Visit: Start Time Variance Greater Then Allowed**
   a. The VSTR error indicates the time variance is too large between Scheduled Service Start/End time and the Actual Visit Start/End time. Check with the Caregiver to verify the reason of a wide time variance. If a valid reason is given, the User can continue clearing the error message.



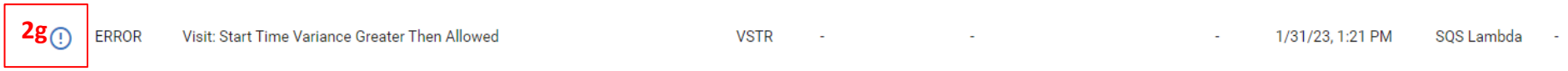
   b. As this is seen as an **ERROR** with the respective icon, ⓘ , a User can clear the error by clicking on the icon. *** This error message requires an adjustment in visit data of the service record BEFORE clearing the message. ***
   c. The Billable Service Start and End time need to be adjusted BEFORE the error message is cleared. Scroll to the **Billable Service Start** or **End** fields, and click the pencil icon by the field, to open the *Edit – Billable Time, Procedure Code/Modifiers, and/or Prior Auth* dialogue box.



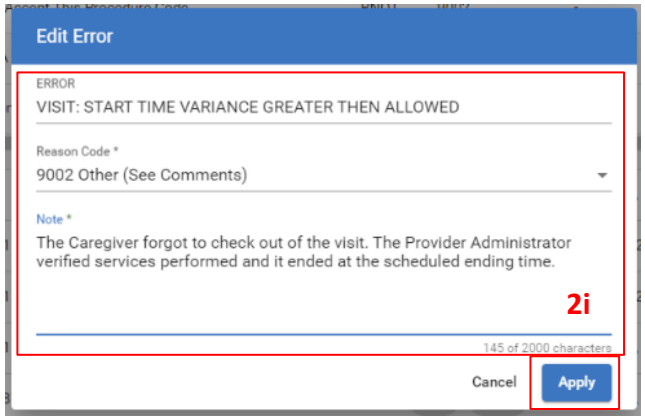


   d. Enter the Billable Service Start and/or End date/time to be billed in the **Billable Service Start and Billable Service End Date/Time** fields.
   e. Select a **Reason Code** and enter a **Note** if required.
   f. Select '**Apply**' to save the changes and close the dialogue box.

g. Scroll back down to the **Edits and Errors** and click the error icon, ⓘ**,** to clear the message.



h. Fill the **Reason Code** and **Note** fields to provide further details in order to clear the message. Click **Apply** to save and clear the error message.



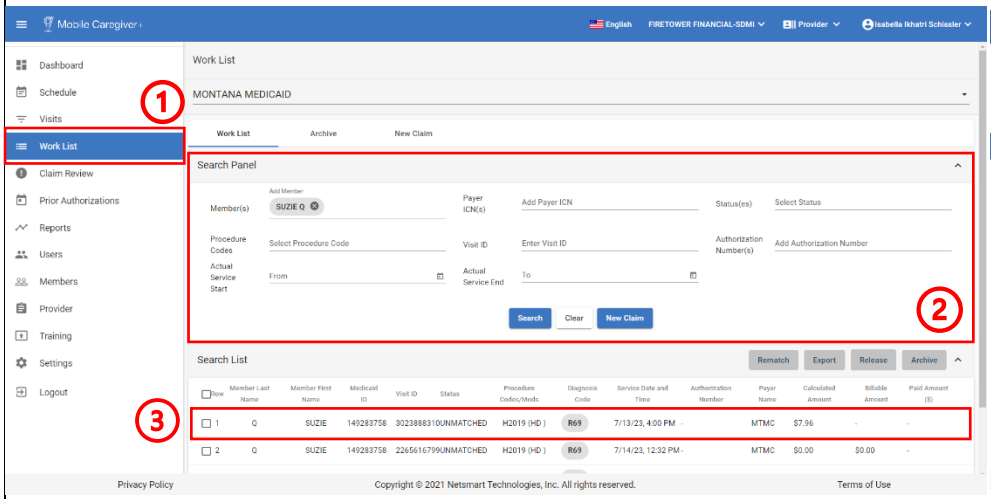
3. Once all errors have been remediated, the service record must be rematched and once the status has been updated to Matched, the service record can be released. *Review instructions on page 1 and 2 for the rematching instructions.*

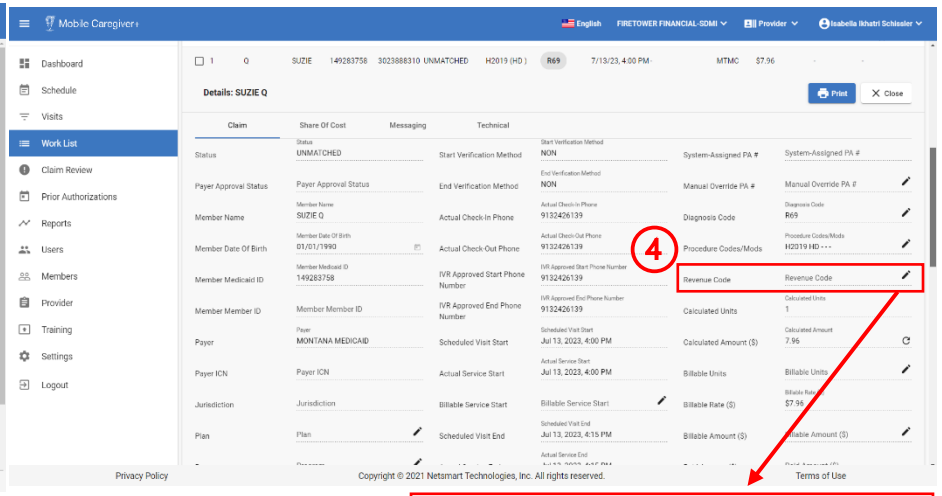
The list below shows the other potential errors that may appear. These errors can be remediated by using one of the methods explained above with the difference of error specific changes.

- **PUNT**: **Prior Authorization: Not Enough Units** – The number of service units that have been withdrawn from the Prior Authorization exceeds the total number of authorized units for the service.
- **RNOT**: **Claim: Payer Not Configured to Accept This HCPCS Code** – The assigned service code is not configured to the Payer.
- **SBAK**: **Scheduling: Backdating Limit Exceeding** – The service date exceeds the cut-off date for timely submission.
- **VDGC**: **Recipient Missing Diagnosis Code** – The service data does not contain the Recipient's Diagnosis Code.
- **VCOV**: **Caregiver (Provider): Scheduled with Overlapping Recipients** – A Caregiver was scheduled in two or more overlapping visits.
- **VDUR**: **Visit: Service Duration Less than Minimum Allowed by Payer** – The recorded service duration time is below the minimum time the Payer has set for billing for one unit of service.
- **VLOC: Visit: Start/End Location Other Than Scheduled –** The Start Variance between the visit's Scheduled Start/End Address and the Actual Start/End location**.**
- **VROV**: **Recipient: Scheduled with Overlapping Caregivers (Providers)** – The scheduled Recipient has two or more overlapping visits.
- **VVER: Visit: Missing Start and/or End Verification** – The service record is missing an EVV check-in and/or check-out time for the billed service.

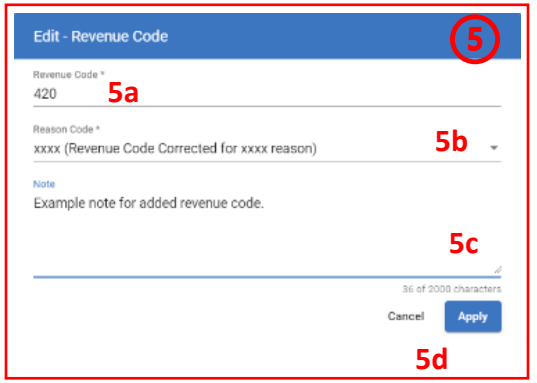
How to Add a Revenue Code to a Claim for Rendered Services

- Depending on the Procedure/ Service Code listed on a claim, a Revenue Code MUST be added before releasing a claim. Revenue Codes must match the Procedure Code listed in a claim. Revenue Codes communicates the setting of where a service was performed for the Recipient.
- **ATTENTION:** Every NE MCO will have their own Revenue Codes for Procedure Codes. Each MCO's Revenue Code will display on the following pages, outlining the Procedure Code that matches.





1. Log into the **Mobile Caregiver+ Provider Portal** and click on the **Work List** tab from the Main Menu.
2. Use the **Search Panel** to locate the claim that needs a revenue code added.
3. Click on the claim record.
    a. All details regarding the selected claim will display.
4. Click the edit icon next to the **Revenue Code** field.
5. The **Edit – Revenue Code** dialogue box will appear.
    a. Type the Revenue Code that matches the listed Procedure Code for the respective claim.
    b. Select a reason for adding a Revenue Code in the **Reason Code** field.
    c. Add a **Note** if needed, to further explain the Revenue Code.
    d. Select **Apply** at the bottom of the dialogue box.



Centene Revenue Codes

Procedure Code	Modifier	File Type	Revenue Code
G0151		837I	421
G0152		837I	431
G0153		837I	441
G0156		837I	571
G0299		837I	551
G0300		837I	551
S9122		837I	552
S9123	TG	837I	552
S9123		837I	552
S9123	UN	837I	552
S9124	TG	837I	552
S9124		837I	552
S9124	UN	837I	552
T1022	TG	837I	552

United Healthcare Revenue Codes

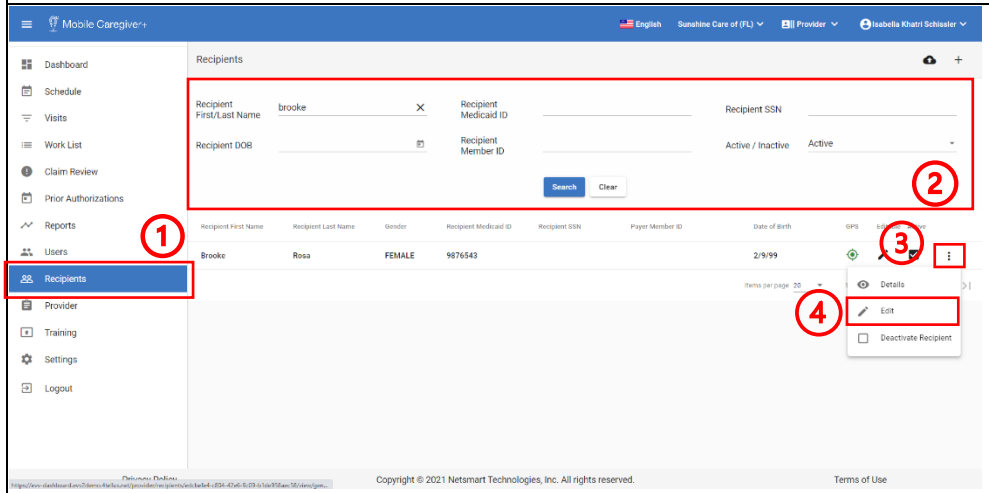
Procedure Code	Modifier	File Type	Revenue Code
G0151		837I	420, 421, 431, 570, 229, 424
G0152		837I	430, 431, 550, 570, 434
G0153		837I	440, 441
G0156		837I	551, 571, 572, 581, 023, 570
G0299		837I	550, 551, 552, 430, 023, 570, 888, 299
G0300		837I	551, 581, 572, 582, 023
S9122		837I	572, 581, 570
S9123	TG	837I	551, 552, 581, 420
S9123		837I	551, 552, 581, 420
S9123	UN	837I	551, 552, 581, 420
S9124	TG	837I	552, 581, 582, 570
S9124		837I	552, 581, 582, 570
S9124	UN	837I	552, 581, 582, 570
T1022	TG	837I	571, 590

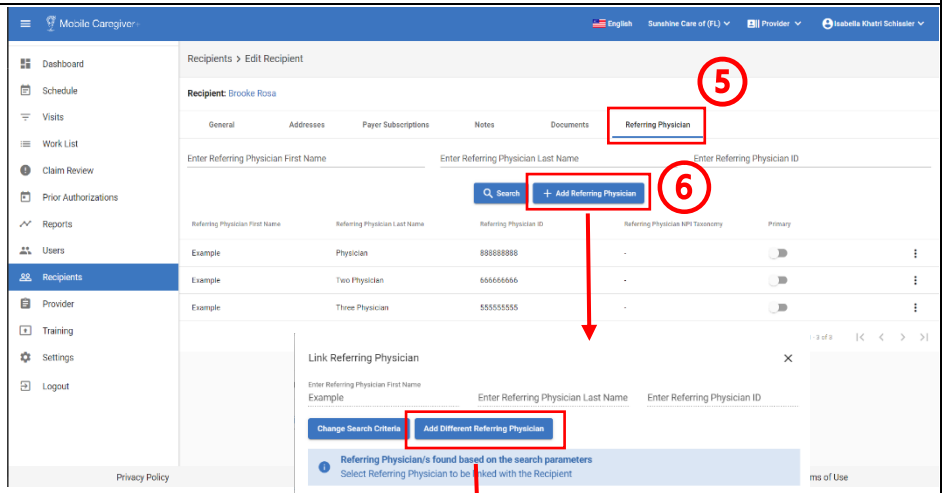
Molina Revenue Codes

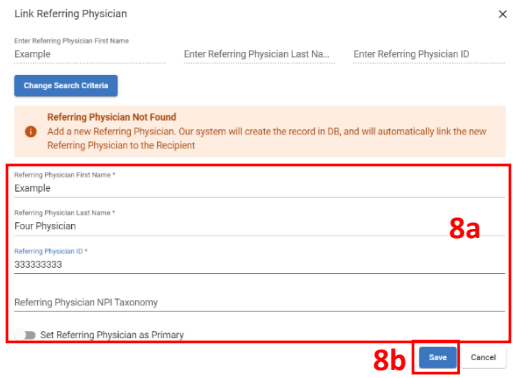
Procedure Code	Modifier	File Type	Revenue Code
G0151		837I	420, 421, 424
G0152		837I	430, 431, 434
G0153		837I	440, 441, 444
G0156		837I	570, 571
G0299		837I	550, 551
G0300		837I	550, 551
S9122		837I	572
S9123	TG	837I	552
S9123		837I	552
S9123	UN	837I	552
S9124	TG	837I	552
S9124		837I	552
S9124	UN	837I	552
T1022	TG	837I	571, 581

How to Add a Referring Physician for Rendered Services

- Depending on the Procedure/ Service Code listed on a claim, a Referring Physician MUST be added before releasing a claim.







1. Log into the **Mobile Caregiver+ Provider Portal** and click on the **Recipients** tab from the Main Menu.
2. Use the search panel to locate the Recipient that needs a Referring Physician added.
3. Click on the action's icon to the right of the selected Recipient.
4. Select **Edit**. The General information of the selected Recipient will display.
5. Click on the **Referring Physician** tab. All current Referring Physicians linked to the selected Recipient will display.
6. Click on the **+ Add Referring Physician** button.
7. The system displays all existing Referring Physicians. If there is an existing Referring Profile that displays, click **Link Physician**.
8. If there is no existing record for the Referring Physician, click on the **Add Different Referring Physician** button.
    a. Enter all the required information for the Referring Physician.
    b. Click **Save** to link the added Referring Physician to the selected Recipient's EVV profile.

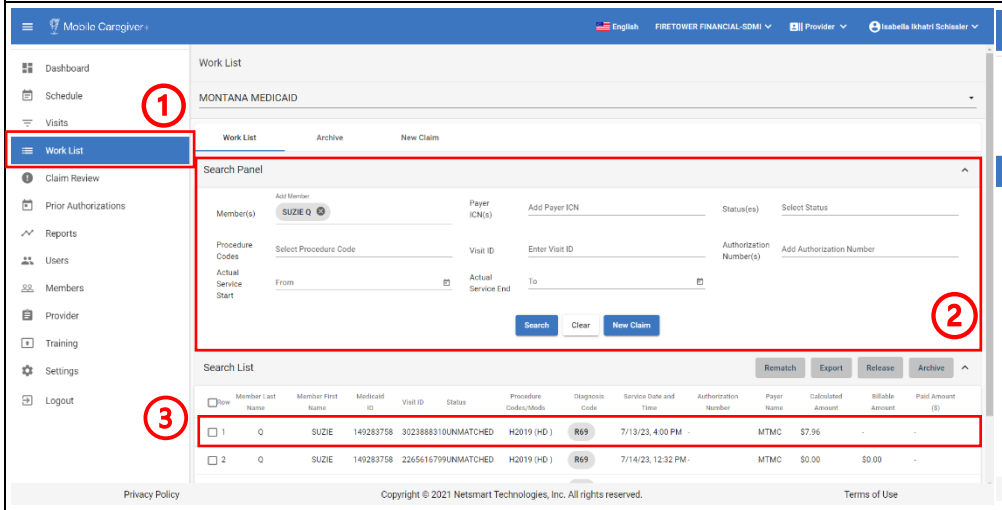
ATTENTION:

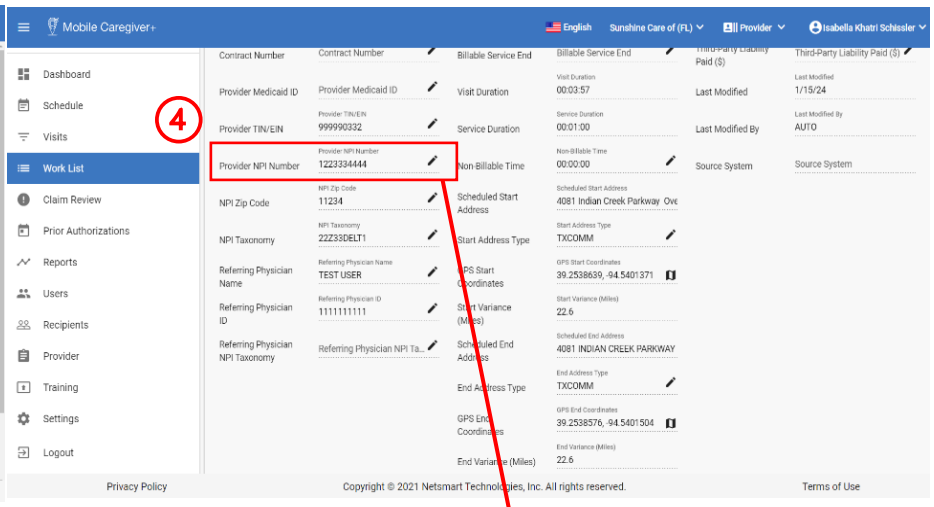
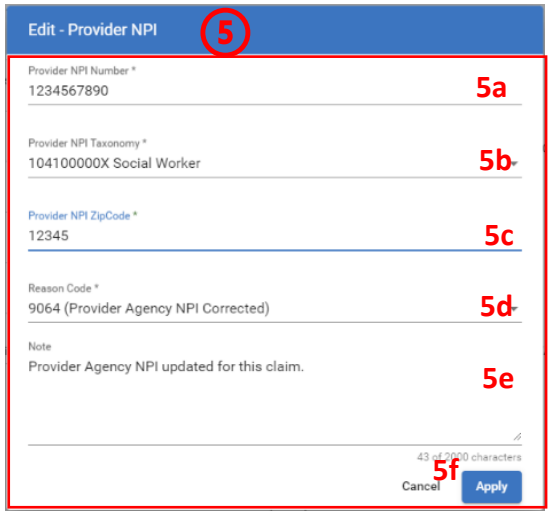
- Referring Physicians can be added to scheduled visits in the **Add New Visit form**, Section 1.
- Referring Physicians can be added to separate claims in the **Work List.**

To review these steps, please visit the Mobile Caregiver+ Provider Portal and Claims Console Full User Guide.

How to Update the NPI for a Claim

- If claims need to be submitted with a different NPI than what your solution displays in the Provider tab or the claim itself. The steps outlined are how to change a NPI within a claim itself.





1. Log into the **Mobile Caregiver+ Provider Portal** and click on the **Work List** tab from the Main Menu.
2. Once a Payer is selected, use the **Search Panel** to locate the claim that needs the NPI changed.
3. Click on the claim record.
    a. All details regarding the selected claim will display.
4. Click the edit icon next to the **Provider NPI Number** field.
5. The **Edit – Provider NPI** dialogue box will appear.
    a. Update the **Provider NPI Number** field that matches the respective claim.
    b. If needed, update the **Provider NPI Taxonomy** field.
    c. Update the **Provider NPI ZipCode** field.
    d. Select a reason for the change in the **Reason Code** field.
    e. Add a **Note** if needed, to further explain the change.
    f. Select **Apply** at the bottom of the dialogue box.