Mobile Caregiver+ Quick Reference Guide
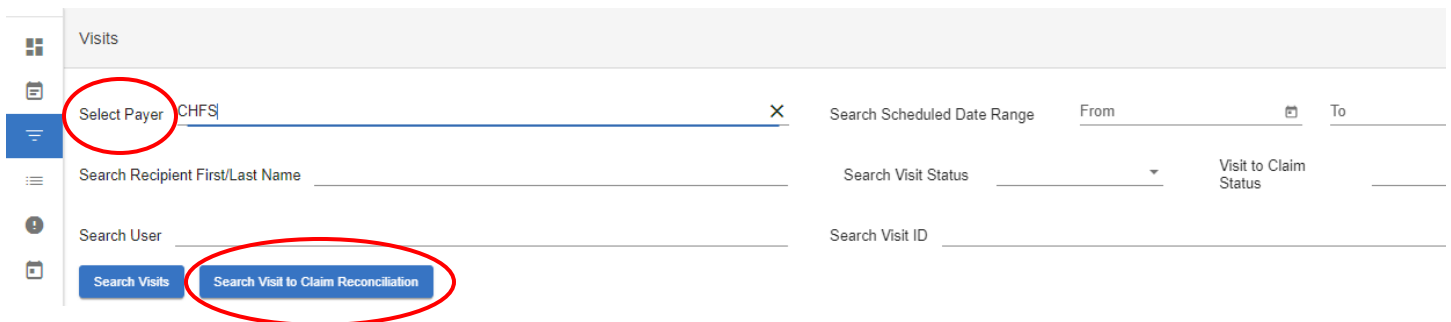## Common Billing Questions for EVV Administrators

This quick reference guide (QRG) outlines the most common billing and claims questions EVV administrators have. Topics in this QRG include:

- Billing Claims Denied for Being a Duplicate
- How to Submit a Denied Claim for Payment

Billing Claims Denied for Being a Duplicate

This occurs when a paid caregiver has more than one visit with the same participant on the same date of service using the same service code. For example, a paid caregiver might provide Personal Assistance to a participant from 9 a.m. to 11 a.m. and again from 4 p.m. to 6 p.m. the same day. If the direct service provider agency or financial management agency (FMA) releases each claim at different times, the Mobile Caregiver+ system identifies one of the claims as a duplicate and it will be denied. **To avoid this scenario, agencies should release these types of claims together so they go out in the same 837 file.** If the claims are not released at the same time and one is denied, agencies should follow the steps below to receive payment.

Log into the Mobile Caregiver+ Provider Portal. Select the **Visits** ☰ page on the left side of the screen. Click in the **Payer** field to generate Kentucky Department for Medicaid Services as the payer. Use the other fields (**Date**, **Recipient**, **Visit Status**, **Visit to Claim Status**, **User** or **Visit ID**) at the top of the page to search for the affected claims. If you want to search claims on a specific date, enter that date in the **Start Date** and **End Date** fields. Once you have entered your search criteria, click the blue **Search Visit to Claim Reconciliation** button.

After the results appear, review the list and look for any visits for the same participant with the same date of service using the same service code that have different start and end times. To assist you in your search, you can sort the results by Visit ID, Scheduled Service Start, Scheduled Service End, Actual Service Start, Actual Service End, Visit Status, Recipient Name, or HCPCS Code/Mods. Click in the column title once to view results in ascending order or click the column title twice to view results in descending order. Note that the results in the

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picture below are sorted by Recipient name as indicated by the up arrow to the right of the column title.

You should have one PAID claim for the participant on that date of service. Any other claims* for the participant provided at different times on the same date of service using the same service code will be listed as DENIED.
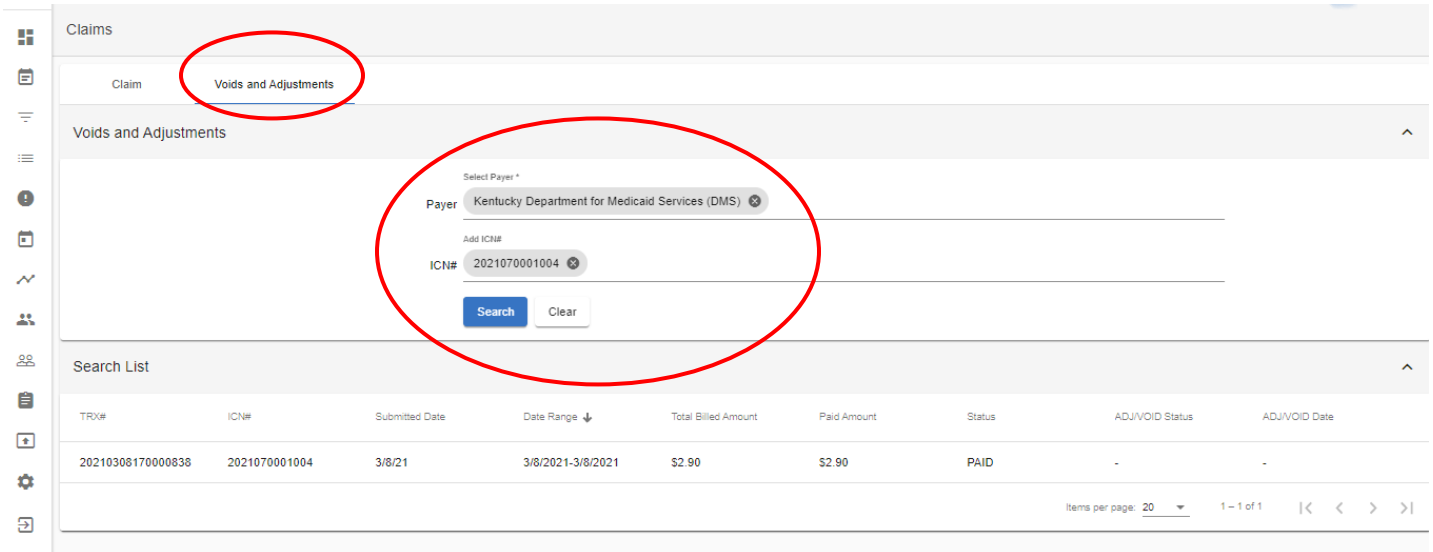
In the example above, there are two claims for Glory Tellus for service code 580 provided on 3/8/21. One visit where services were rendered the morning of 3/8/21 is PAID. A second visit where services were rendered the afternoon of 3/8/21 is DENIED.

Make sure there are no PAID claims for the date of service and timeframe of the DENIED claim(s). Once you have confirmed none of the DENIED claims have been paid out, write down the ICN for the PAID claim. The ICN is found in the second to last column from the right.

Note: If you have more than two visits for the same participant on the same date of service using the same service code, you may have one PAID claim and multiple DENIED claims.

Next, go to **Claims Review** 🛈 on the left side of the Provider Portal. When the page loads, choose the **Voids and Adjustments** tab. Click in the **Payer** field to generate the Kentucky Department for Medicaid Services as the payer, type the ICN into the **ICN#** field, and click the blue **Search** button. When the PAID claim appears, click anywhere in the row. This will open up the claim details.

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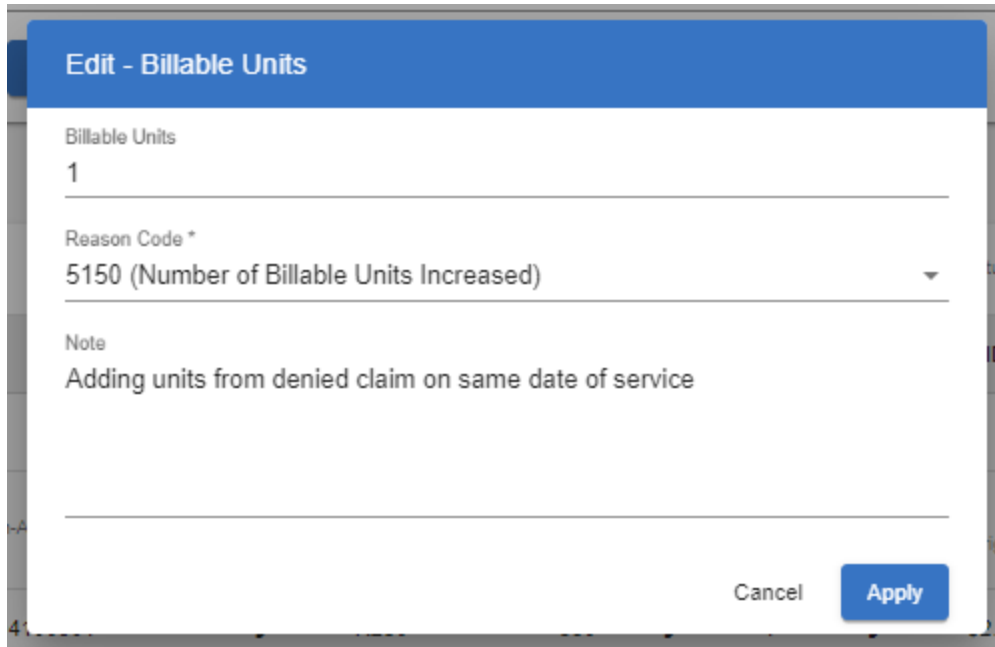
Look for the **Billable Units** field and click the pencil icon next to edit it. A box will appear. Add the number of units from the DENIED duplicate claim(s). Once you have done this, you will need to add a reason code. Use reason code 5150 (Number of Billable Units Increased). You also need to enter a note indicating you are adding units from a claim(s) with the same date of service that was denied. After making these edits, click **Apply**.

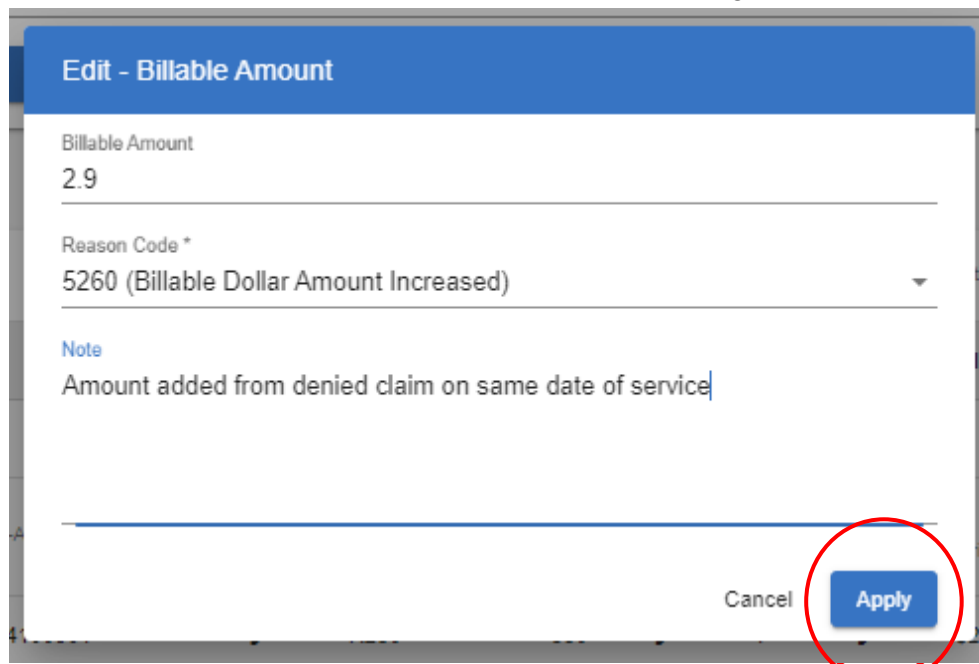**Mobile Caregiver+ Quick Reference Guide**
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CHFS
Cabinet *for* Health *and*
Family Services

Edit - Billable Units

Billable Units
1

Reason Code *
5150 (Number of Billable Units Increased)

Note
Adding units from denied claim on same date of service

Cancel   **Apply**

Next, you will adjust the **Billable Amount**. Click the pencil icon next to the **Billable Amount** field. A box will appear. Adjust the billable amount to reflect the total is should be for both the PAID claim and the DENIED duplicate claim(s). Again, you will need to enter a reason code. Choose 5260 (Billable Dollar Amount Increased) and enter a note indicating you are adding the dollar amount from a claim(s) with the same date of service that was denied. After making these edits, click **Apply**.
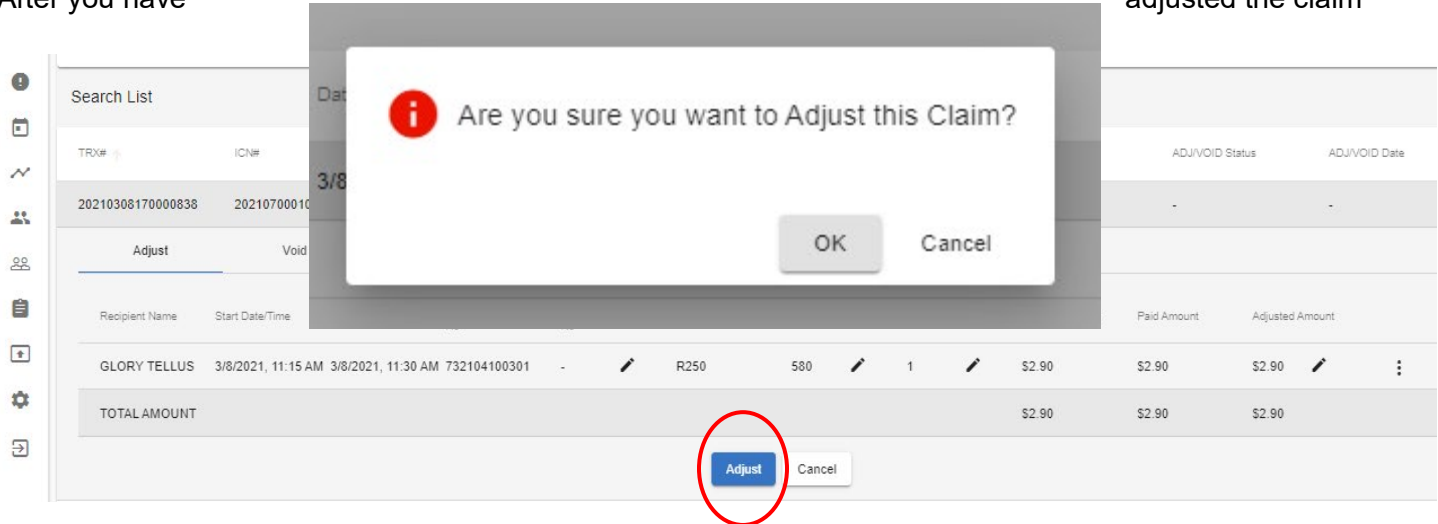

Edit - Billable Amount

Billable Amount
2.9

Reason Code *
5260 (Billable Dollar Amount Increased)

Note
Amount added from denied claim on same date of service

Cancel   **Apply**

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After you have   adjusted the claim

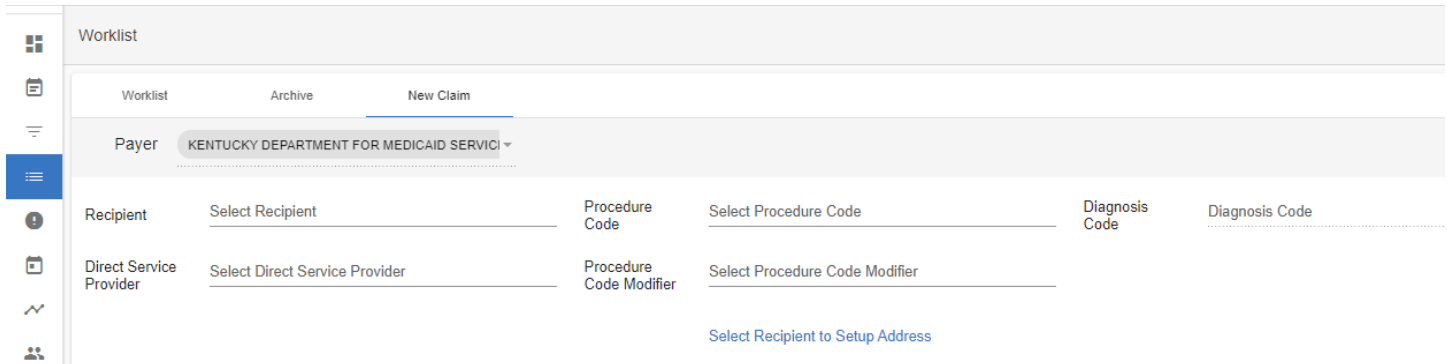using the steps above, click the blue **Adjust** button.

A confirmation message will appear. Click **OK**.

The claim is now adjusted and is viewable under the **Voids and Adjustments** tab under **Claim Review**.

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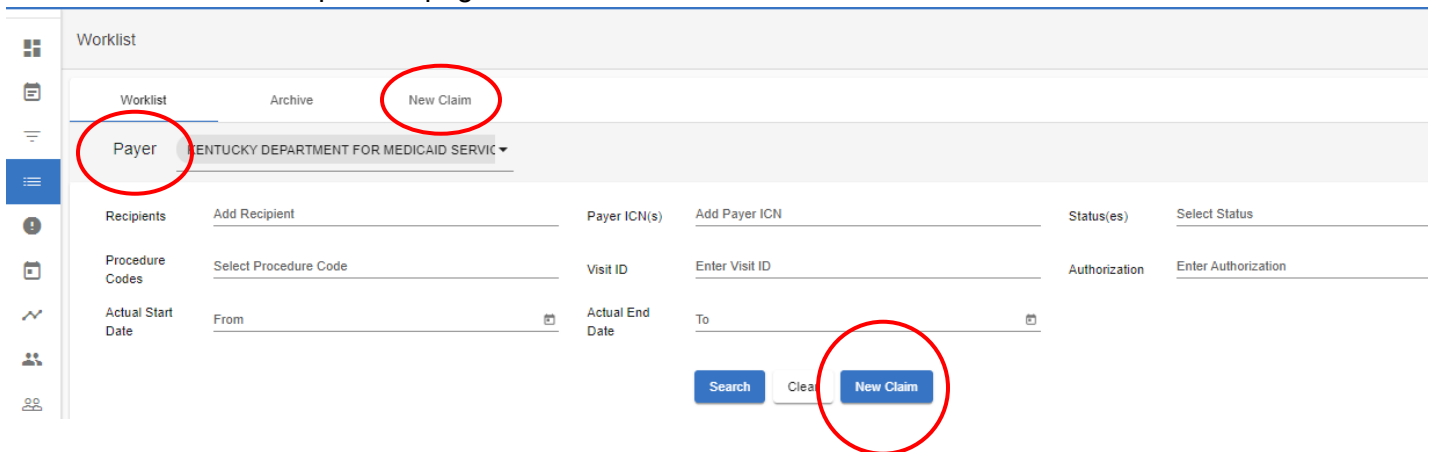
How to Submit a Denied Claim for Payment

Denied claims cannot be adjusted in the Mobile Caregiver+ system nor can a user resubmit a denied claim. If

an agency needs to submit a denied claim for payment, the user will need to create and submit a manual claim following the steps below. **You can only create and submit a manual claim if the original claim was denied for incorrect diagnosis, incorrect provider ID, or incorrect member ID.**

Log into the Mobile Caregiver+ Provider Portal. Choose the **Work List** icon on the left side. First, click in the **Payer** field to generate the Kentucky Department for Medicaid Services as the payer. Next, click either the **New Claim** tab at the top of the page or the blue **New Claim** button.

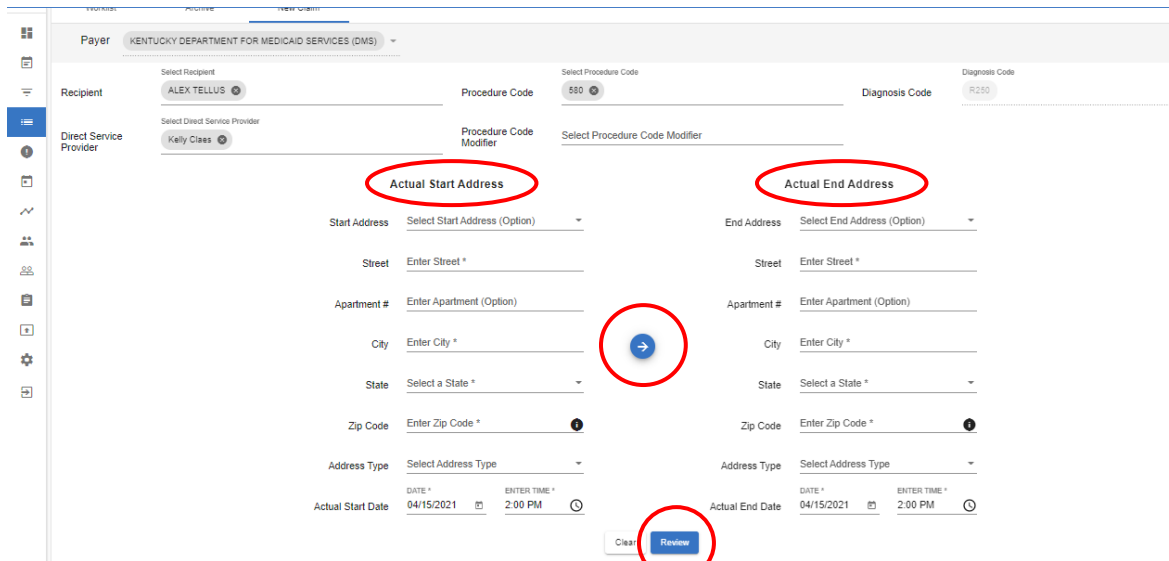You must enter the **Recipient Name**, the **Direct Service Provider** name (or PDS employee name), and the **Procedure Code**. These are required fields.

Once you have done this, additional fields will populate. Enter the **Actual Start Address** and the **Actual End Address** for the service visit. You can use the down arrow in the **Start Address** field to select from the

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Updated: 7/14/21

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addresses stored in the system for the recipient or you can add the address manually. If the **Actual Start Address** and **Actual End Address** are the same, you can click the blue arrow between the two fields to automatically populate the **Actual Start Address** in the **Actual End Address** field.
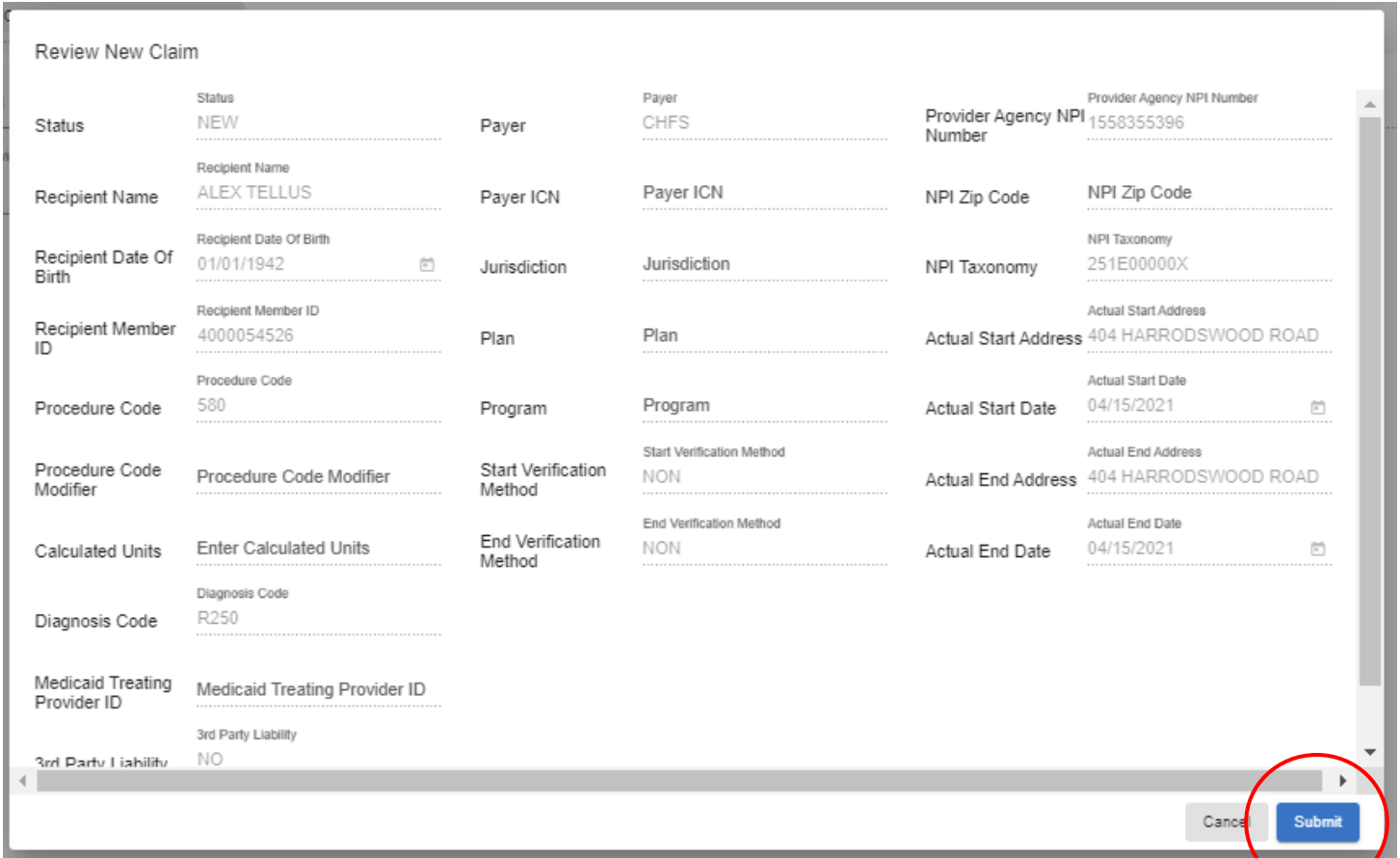
Next, enter the date and time of the visit in the **Actual Start Date** and the **Actual End Date** fields. Once you have done this, click the blue **Review** button.

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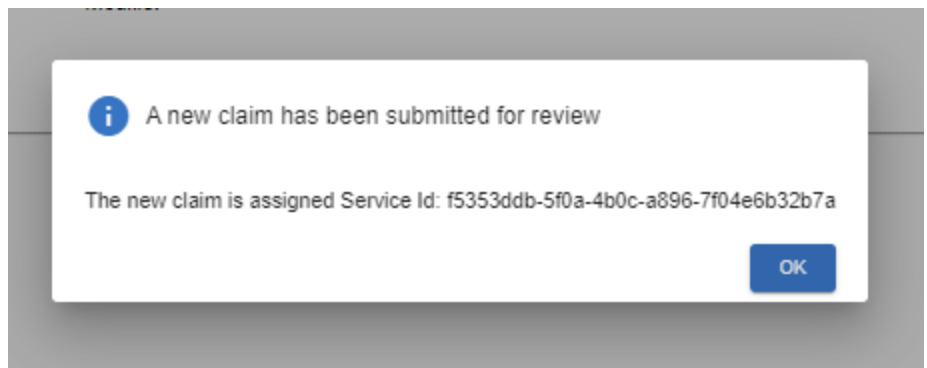**Common Billing Questions for EVV Administrators**

After clicking **Review**, a box will appear with all of the information you entered. Please review the information and, after verifying it is correct, click the blue **Submit** button.

Review New Claim

Status	Status **NEW**	Payer	Payer **CHFS**

Provider Agency NPI Number: 1558355396

| Recipient Name | Recipient Name **ALEX TELLUS** | Payer ICN | Payer ICN |
| NPI Zip Code | NPI Zip Code |

| Recipient Date Of Birth | Recipient Date Of Birth **01/01/1942** | Jurisdiction | Jurisdiction |
| NPI Taxonomy | NPI Taxonomy **251E00000X** |

| Recipient Member ID | Recipient Member ID **4000054526** | Plan | Plan |
| Actual Start Address | Actual Start Address **404 HARRODSWOOD ROAD** |

| Procedure Code | Procedure Code **580** | Program | Program |
| Actual Start Date | Actual Start Date **04/15/2021** |

| Procedure Code Modifier | Procedure Code Modifier | Start Verification Method | Start Verification Method **NON** |
| Actual End Address | Actual End Address **404 HARRODSWOOD ROAD** |

| Calculated Units | Enter Calculated Units | End Verification Method | End Verification Method **NON** |
| Actual End Date | Actual End Date **04/15/2021** |

| Diagnosis Code | Diagnosis Code **R250** | | |

| Medicaid Treating Provider ID | Medicaid Treating Provider ID | | |

| 3rd Party Liability | 3rd Party Liability **NO** | | |

Cancel   **Submit**

You should receive a confirmation message that your claim has been submitted for review and giving you a service ID for the claim.

ⓘ A new claim has been submitted for review

The new claim is assigned Service Id: f5353ddb-5f0a-4b0c-a896-7f04e6b32b7a

OK

The visit will now appear in the work list with a status of New until the pre-adjudication process occurs. After that, the visit status will be changed to

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Matched or Unmatched. Once in Matched status, a visit can be released for payment. Unmatched visits must be updated and Matched before being released for payment.

Additional Resources

A complete list of EVV resources is available in the EVV QRG: Who to Call listing, the DMS EVV website at https://bit.ly/kywaiverEVVinfo, or by scanning the QR code to the left using your mobile device.

If your direct service provider agency or FMA has a technical issue with Mobile Caregiver+, you can submit a support ticket using the Netsmart Customer Support Portal or by calling (833) 483-5587.

If you have a question about EVV policy, contact the 1915(c) Waiver Help Desk at 1915cWaiverHelpDesk@ky.gov or (844) 784-5614.