Billing Housing Stabilization Services: FAQ for Providers

For providers who are new to the healthcare world, the systems and terminology around billing can be confusing. This FAQ is intended to help new providers gain a better understanding of these concepts and learn tips to move forward with your agency's implementation.

Fee-for-service v. Managed Care Organizations (MCO)

How do I know whether to submit a claim through MN-ITS or bill the person's Managed Care Organization?

Anyone enrolled in an MCO for Medical Assistance (MSHO, MSC+, SNBC or PMAP) will receive their Housing Stabilization Services through the MCO. You will bill their MCO for any Housing Stabilization Services provided. To find out if a person is enrolled in an MCO, you can verify member eligibility and the MCO enrollment status through the MN–ITS Eligibility (270/271) transaction prior to performing services[1]. Knowing what MCOs cover the people you serve will help you determine which MCOs you work with and how to prioritize MCO engagement.

For information about billing an MCO, you will need to contact the MCO directly. The first step for newly enrolled Housing Stabilization Services providers will be to talk to an MCO representative assigned to Housing Stabilization Services. Refer to the contacts listed on the DHS Housing Stabilization Services policy page for the name and contact information for each MCO. This person will help you get your agency set up for serving MCO members and submitting claims.

Billing processes can differ from MCO to MCO. The chart below provides contact information and a link to billing information on the MCO's website. For detailed questions on billing, the MCOs will commonly direct you to their Provider Relations departments and claims specialists.

MCO	Billing information	Provider services contact[2]
Blue Plus	Availity claims submission	Provider Service Center: 866-518-8448
HealthPartners	Claims submissions	Professional Services Network Mgmt: 952-883-5589
Hennepin Health	Electronic transactions guidelines	Provider Help Desk and Contracting: 612-596-1036, option 2

1 https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008923

2 https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008924

MCO	Billing information	Provider services contact[2]
Itasca Medical Care	Billing Policy	Provider Services and Contracting: 800-843-9536
Medica	Claim tools	Provider Services and Contracting: 800-458-5512
PrimeWest Health	Claims & Payment	Provider Services and Contracting: 866-431-0802 or 320-335-5359
South Country Health Alliance	Claims	Provider Help Desk: 888-633-4055
UCare	Claims & Billing	Provider Assistance Center: 612-676-3300 or 888-531-1493

MCOs commonly have contracts with providers of services, and then that provider is called an 'In Network" provider for the MCO. MCOs will not be requiring Housing Stabilization Services providers to have contracts with them to provide Housing Stabilization Services. In some cases, however, it may be easier for agencies to administratively manage the Housing Stabilization Services program if your agency has a contract or an agreement in place with the MCO. This is because Housing Stabilization Services agencies that are not considered "In Network" may have additional forms to submit for every claim for payment made to the MCO. Contracts can take up as long as 90 days or more to set up with the MCO. Providers who are "In Network" also are commonly assigned a staff person at the MCO who is their initial point of contact for support.

MCOs will not work with agencies until they are enrolled as Housing Stabilization Services providers, so wait until your provider enrollment through DHS is in place before contacting them. DHS will notify the MCOs in your county that you have been approved as an HSS Provider.

When do I submit claims through MN-ITS?

Housing Stabilization Services recipients that are not enrolled in an MCO are considered part of the fee-for-services delivery system. Claims for Housing Stabilization Services for these recipients should be billed through MN-ITS.

Clearinghouses

What is a clearinghouse?

Clearinghouses allow healthcare providers to confirm that their payment claims are error-free before submitting them. Clearinghouses also translate claims into standard formats compatible with the payer's software.[3]

When do I need to use a clearinghouse?

[3] https://healthinformatics.uic.edu/blog/what-is-healthcare-reimbursement/

All MCOs in MN require that claims be submitted to a clearinghouse first. The clearinghouse uses electronic processes to make sure that the claim is 'clean'. A claim is considered 'clean' is filled out and submitted correctly so that the MCO can easily process and pay on the claim. Since this process is done electronically, the material submitted must be EXACTLY correct, and there is no room for error.

How do I decide which clearinghouse to use?

You need to learn what MCOs are covering the people you serve and then what clearinghouses those MCOs use. This information is summarized for Minnesota Medicaid health plans in Table 1. Your agency will need to submit to the appropriate clearinghouse that is used by the MCO that you are billing.

TABLE 1: Clearinghouses and the MCOs that use them for claims submission

Clearinghouse	**MCO**							
	Blue Plus	HealthPartners	Hennepin Health	Medica	UCare	PrimeWest	IMCare	South Country Health Alliance
Availity	✓	✓	✓	✓	✓	✓	✓	✓
Change Healthcare		✓	✓	✓	✓	✓	✓	✓
Smart Data Solutions		✓	✓		✓	✓	✓	✓
COBA							✓	
Cortex EDI					✓			
EDS						✓	✓	
eProvider Solutions					✓	✓		✓
HFMI					✓			
MN E-Connect		✓	✓	✓	✓	✓	✓	✓
Office Ally						✓	✓	✓
PNC					✓	✓		✓
PNT Data		✓						
Relay Health			✓					
Rycan							✓	✓
SSI Group					✓			
Tesia						✓		
TriZetto						✓		✓
TruBridge					✓	✓	✓	
Waystar					✓	✓		✓
Other*			✓		✓	✓		✓

*MCOs with a check in the "Other" column allow you to use any clearinghouse of your choice. Because of this, although Hennepin Health's forms do not explicitly include checkboxes for Availity and MN E-Connect, those two clearinghouses are options for Hennepin Health.

Most clearinghouses charge a fee to use them. However, the following clearinghouses offer free options:

- Office Ally: Free for billing to PrimeWest, IMCare, and South Country Health Alliance.
- Availity: Free for billing to Blue Plus only. *(Note: While Availity works with all of the MCOs, it requires a paid subscription to bill to any MCO other than Blue Plus.)*
- MN E-Connect: Free for billing to all of the MCOs except for Blue Plus for manual claims only. More advanced options such as batch claims submissions require a paid subscription.

Electronic Health Records (EHR)

What is an Electronic Health Record?

An electronic health record (EHR) is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider's office and can be inclusive of a broader view of a patient's care. EHRs are a vital part of health IT and can:

- Contain a patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory and test results
- Allow access to evidence-based tools that providers can use to make decisions about a patient's care
- Automate and streamline provider workflow

One of the key features of an EHR is that health information can be created and managed by authorized providers in a digital format capable of being shared with other providers across more than one health care organization. EHRs are built to share information with other health care providers and organizations – such as laboratories, specialists, medical imaging facilities, pharmacies, emergency facilities, and school and workplace clinics – so they contain information from *all clinicians involved in a patient's care*.[4]

Do I need to have an EHR to bill for Housing Stabilization Services? Will an EHR help me with the billing process?

No, an EHR is not a requirement for Housing Stabilization Services providers. Depending on the specific EHR and the system you currently have for collecting client information, purchasing an EHR may or may not make the billing process easier for you. You will still need to use a clearinghouse to submit claims to an MCO. The primary purpose of an EHR is not billing but storing health records for the people that you serve.

[4] https://www.healthit.gov/faq/what-electronic-health-record-ehr

What considerations should I make when deciding whether or not to purchase an EHR?

An EHR is potentially helpful if you: 1) will be providing healthcare services beyond Housing Stabilization Services; 2) want to share patient information with clinicians and providers outside of your agency; or 3) need a secure place to store client information electronically.

An EHR may not be necessary if: 1) You will not be providing healthcare services beyond Housing Stabilization Services; 2) You are serving a small number of Housing Stabilization Services recipients; or 3) You already have a secure place to store client information.

Many EHRs include a medical billing component either integrated into their software or as an add-in. If you are considering purchasing medical billing software, you may want to look at EHRs as an option as well.

How do I decide which EHR to purchase?

- Talk through your internal process from service to documentation to billing. Include staff who will be using the systems to be part of the group that decides on your agency's process.
- Discuss with your team what you want the end result to be in an EHR.
- Think big and scale back as needed.
- Schedule meetings with agencies who already use a EHR to discuss the pros and cons and cost.
- Ask potential EHR companies:
    - What does the software do without any individualized tailoring (i.e.: what was it meant for)? What are the system defaults?
    - Do they provide ongoing technical support? What is the cost of that support?
- Get three estimates and schedule test runs.
- Get references from people who currently use the system regularly.
- Compare what you get for the cost.

Third-party billing

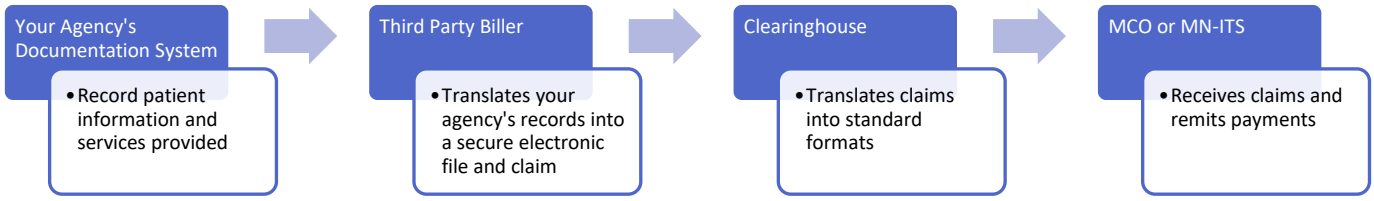
What does a third-party billing agency do?

A third-party billing agency submits claims to Clearinghouses, so that your agency does not have to. They grew out of the need for small medical practices, which did not have the volume of claims or business to make it worthwhile to adopt an Electronic Health Record or hire a full-time billing specialist. Working with a third-party billing agency might make sense for your agency if you expect that your volume of HSS services also does not warrant these investments.

What are the benefits and drawbacks to working with a third-party billing agency?

The benefits of third-party billing are their expertise in submitting claims, having the electronic software to work efficiently with clearinghouses and MCOs. The primary downside is that your agency will have to pay for their services, so this will decrease the revenue that your agency is generating from billing for Housing Stabilization Services.

Process with a Third-Party Biller



How do I choose a third-party billing agency?

As with an E.H.R. the best advice is to talk to other agencies that are using the service and see how satisfied a customer they are. Consider the following steps:

- Interview multiple agencies to learn what they provide and at what cost.
- Talk through your internal process and how your current documentation systems will translate into what the third-party biller needs to perform their function. Don't forget that records need to be secure to transfer from your agency to the third-party biller.
- Discuss with your team what you want the end result to be in using this service. Do you envision this as a permanent relationship, or short term to help your agency transition to Housing Stabilization Services?
- Think big and scale back as needed.
- Schedule meetings with agencies who already use these third-party billers to discuss the pros and cons and cost.
- How does the third-party biller deal with rejected claims? How will they support you to be sure that you are paid consistently and timely?
- What about ongoing support? What is the cost of that support?
- Compare what you get for the cost.

Troubleshooting

Claims are frequently rejected, mostly for reasons that can be simple to fix. When a claim is rejected, your agency should have a standard process for revising and resubmitting the claims.

Common reasons claims are rejected

- The person is not an active enrolled member of the MCO on the day of service. In most instances, this cannot be fixed, and is why agencies need to check service recipient enrollment regularly. Agencies can attempt to re-enroll the service participant in Medical Assistance and the MCOs and retroactively bill the MCO. Most MCOs have policies regarding how long they will accept billing AFTER the service has occurred and most commonly that time frame is 90 days.

- The service occurred outside the time window for billing, i.e., if the MCO billing window is 90 days and the service occurred 91 days ago.

- The claim does not include required information on the claim. This can be information required by the MCO or by DHS.

- The information on the claim does not EXACTLY match the information the MCO has on the client. For example, Michele and Michelle are not exact matches.

- There is a break in logic in the claim, for example the 'start' date and time for the service is after the 'end' date and time for the service.

- The claim does not match the services MCO records show that the service recipient was authorized for.

MCOs have staff who are assigned to support each agency they contract with. It is important for agencies to know who this person is and create a positive relationship with this person, because they are your first line of contact to the MCO when claims are rejected.