Mobile Caregiver+ Claims User Guide

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Version 3.6.0

Contents

Terminology

The following terms are used throughout the application and throughout this User Guide:

- **Administrator (Admin):** A Mobile Caregiver+ User Role that grants a User full access to all available features and functions of the Provider's Mobile Caregiver+ Provider Portal. The Fiscal Agent and Fiscal Intermediary roles also grant Users the same access privileges as an Administrator. Users assigned the role of Administrator, Fiscal Agent, or Fiscal Intermediary will have access to data for all recipients in the provider agency. Depending on the Payer and Program, Administrators may have rights to Manage some, or all, objects in an agency's EVV portal.

  Note: Multiple User roles can be assigned to a single User account. For example, if a User works in the Office as an Administrator and assists in providing coverage for Caregivers, the User will have to be assigned both the Administrator Role and the Caregiver Role.

- **Billing:** A Mobile Caregiver+ User role that grants a User limited access to the claims processing features and functions of an agency's Mobile Caregiver+ Provider Portal. The Biller Role can be assigned to contractors to allow them to effectively process claims, while limiting access to other confidential data.

- **Monitor:** A Mobile Caregiver+ User Role that grants a User limited view-only access to scheduling and Recipient data in an agency's EVV Portal; Provider Viewers can view, but are not allowed to edit, scheduled visit data and Recipient data. Users that are assigned the role of Provider Viewers will have access to view data for all Recipients in the provider agency.

- **Caregiver:** A limited Mobile Caregiver+ User Role that allow Users to download, install, and login to the Mobile Caregiver+ app to complete scheduled visits. The Caregiver User role is usually assigned to the following: Live-in Service Providers, Rendering Providers, Billing Providers, Home Health Aides, Adult Daycare Providers, Providers, Community Mental Health Providers, Agency Providers, PDS Employees, Independent Providers, Service Providers, Participant Directed Service Providers, Personal Care Providers, Group Home Providers, Direct Care Workers, Direct Service Providers, Non-Agency Providers.

- **Healthcare Common Procedure Coding System (HCPCS):** HCPCS is a standardized healthcare coding system that is used primarily to identify services provided; also

known as: Service Description: Billing Codes, Procedure Codes, Revenue Codes. (See also Service Codes).

- **Service Code:** A code, which can be a combination of letters and numbers, that represents a healthcare service conducted (see also HCPCS codes). Payers assign Service Codes to represent billable healthcare services.

- **Modifier:** (Supplement to the *HCPCS Codes*/*Service Codes*) Two digits used for billing to provide extra details (when applicable) concerning a service/care provided by a Caregiver; not all service codes have modifiers.

- **Agency:** A business established to provide a service and employs individuals to render care; also known as: Traditional Home Health Agency, Fiscal Management Agency (FMA), Provider Agency, and Billing Provider.

- **Payer:** The health plan or organization which provides payment to the Caregiver or Agency for services provided to Recipients by Caregivers.

- **Prior Authorization/Service Authorization:** Method through which Health plans authorize care for a Recipient for a specified period, for a specified unit (time increment for a service code), or for a specified number of visits.

- **Recipient:** An individual receiving services/care is also known as: Client, Participant, Individual, Family Member (child, parent, spouse, etc.) PDS Employer, or Beneficiary.

- **Schedule:** A plan for rendering services, which includes pre-planned visits. Visits can be planned/scheduled by Administrators for Caregivers to provide services to Recipients. In some environments, Caregivers may be responsible for scheduling visits.

- **Visit:** A scheduled date, time, and place for a Caregiver to provide services to a Recipient.

Note: All screenshots included in this user guide are fabricated test data and do not include any PHI.

Getting Started

You are here: Mobile Caregiver+ Claim Console > Getting Started

Click on one of the below topics:

Getting Started

Viewing Dashboard Analytic Reports

Main Menu

About Claims Processing

Claims Console Visit List

The Work List

Claim Review

Prior Authorization

Reports

Logging In

You are here: Mobile Caregiver+ Claim Console > Getting Started > Logging In

Note: Be sure pop-up blockers are turned off before logging in to the Mobile Caregiver+ Claim Console.

You can access the Mobile Caregiver+ Claim Console using any web browser.

1. Type mobilecaregiverplus.com in the address bar of your browser.
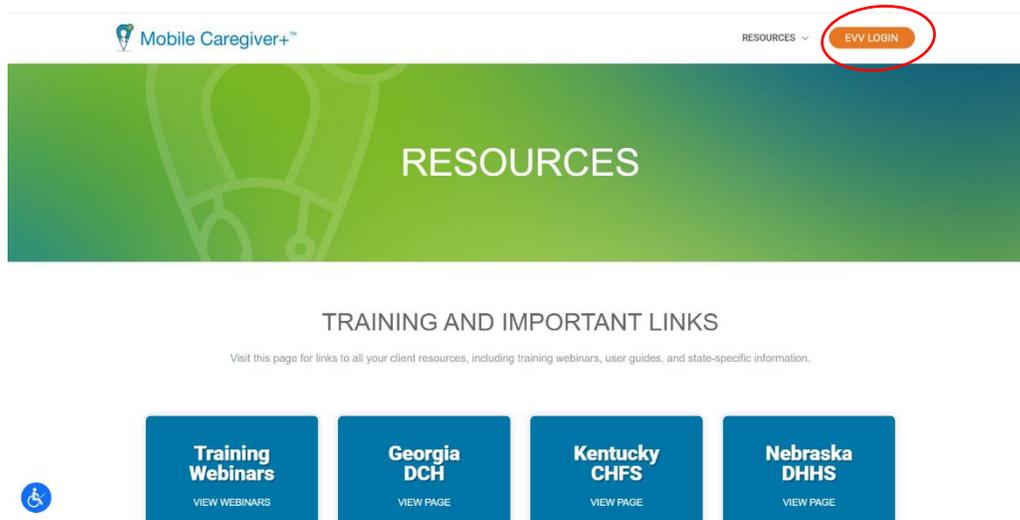
2. Click **EVV LOGIN** in the upper right-hand corner.

   The system will display the Mobile Caregiver+ Claim Console Login dialog box.

3. Enter your Username and Password.

4. Click **Login**.

The Mobile Caregiver+ Claim Console opens to the Dashboard view.

Note: If you forget your password, click the Forgot Password link to conduct self-service password reset. You will receive an email with a temporary link that will allow you to log in and change your password.

Users that are assigned the **Billing** or **Monitor** user roles will receive an email invitation to join the agency that issued the invitation. You have 36 hours to log in and activate your account; after that time the invitation expires.

If you do not find the email in your inbox, check your junk and spam folders for the email from the Mobile Caregiver+ System.

Viewing Dashboard Analytic Reports

You are here: Mobile Caregiver+ Claim Console > Getting Started > Viewing Dashboard Analytic Report

Topics Covered in this chapter

- My Claims Work Queue

- Released Claims Pending Submission

- Claims

When Providers login to the Mobile Caregiver+ Claim Console, the system automatically displays the Dashboard. The Dashboard provides a snapshot overview of near real-time and/or real-time EVV analytic data.

There are three Dashboard screens that display claims analytic data: My Claims Work Queue, Released Claims Pending Submission, and Claims. Scroll down to see claims analytic data.

My Claims Work Queue

You are here: Mobile Caregiver+ Claim Console > Getting Started > Viewing Dashboard Analytic Reports > My Claims Work Queue

The My Claims Work Queue displays information about service records in the Work List. Provider can select either a Pie Chart or a Table that displays the number of New, Matched, and Unmatched service records currently in the Work List.

Completed services are processed and transferred to Work List.

Mobile Caregiver+ uses "payer-rules" to screens (pre-adjudicates) service records that are transferred to the Work List. Service records that are screened are either labeled:

- **Matched** – Service records which have no reported errors and can be released for remittance. Only Matched service records can be released for claims submission.

- **Unmatched** – Service records which have reported errors that must be remediated and rescreened to change the status to Matched.

The My Claims Work Que report displays real-time information about service records in the Work List.

1. From the View as tab, click **Chart** to view a Pie Chart report displaying the number of New, Matched, and Unmatched service records currently in the Work List.

My Claims Work Queue Chart Report
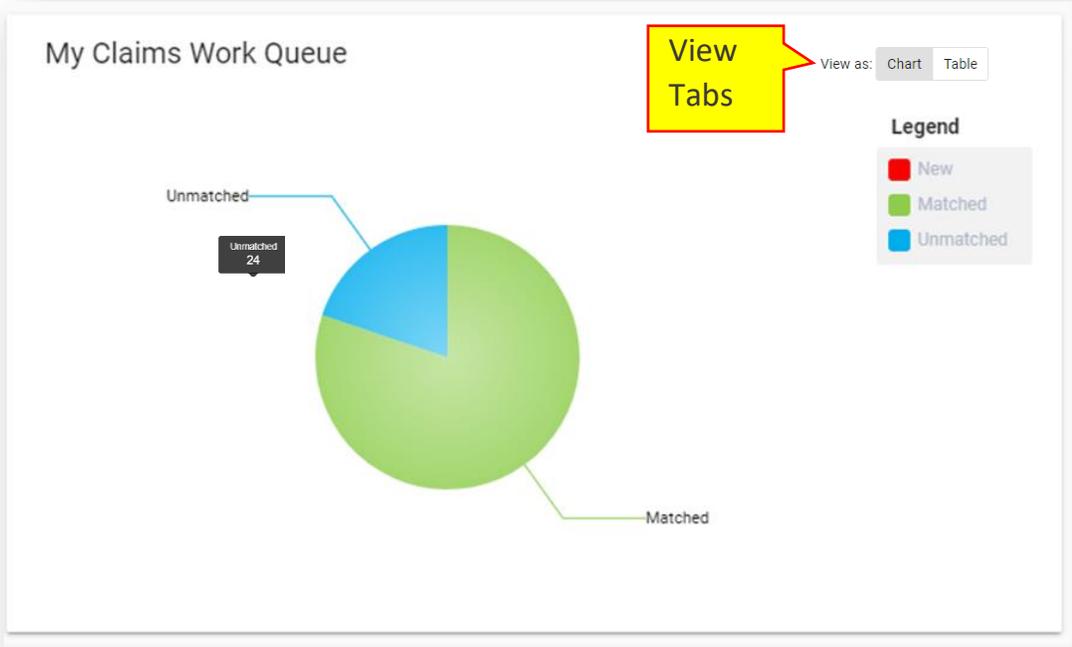
2. Hover your cursor over a section of the pie chart to see the actual number of claims in each section.

3. Click on the chart to view the corresponding service records in the Work List.

4. From the View as tabs, click **Table** to view a Table report displaying the number of New, Matched, and Unmatched service records currently in the Work List.

My Claims Work Queue Table Report

Claims   View as: Chart   Table

	Choose start date *	Choose end date *						
Custom ▾	05/01/2021 📅	05/17/2021 📅						↻

Start Date	ACCEPTED	ADJUSTED	DENIED	ERROR	MATCHED	NEW	PAID	PAID PARTIAL	REJECTED	RELEASED	SUBMITTED	VOIDED	UNMATCHED
Saturday, May 1, 2021	0	0	0	0		0	0	0	0	0	0	0	0
Sunday, May 2, 2021	0	0	0	0		0	0	0	0	0	0	0	0
Monday, May 3, 2021	0	0	0	0		0	0	0	0	25	0	0	0
Tuesday, May 4, 2021	0	0	0	0		0	51.66	0	0	0	0	0	77.00999999999999
Wednesday, May 5, 2021	0	0	0	0		0	0	0	0	48.9	0	0	55.55
Thursday, May 6, 2021	0	51.66	0	244.06		0	289.98	0	0	249.98	0	0	63.86
Friday, May 7, 2021	0	0	0	0		0	0	0	0	0	0	0	0

Released Claims Pending Submission

Providers will release Matched service records for claims submission.

The Release Claims Pending Submission report displays the total estimated payment amount for the corresponding list of released service records in Claim Review (service records that have not yet been submitted to a Payer).

1. Click on the displayed estimated payment amount to view the corresponding list of Release service records in Claim Review.

Released Claims Pending Submission Report

Claims Report

You are here: Mobile Caregiver+ Claim Console > Getting Started > Viewing Dashboard Analytic Reports > Claims Report

The Claims report displays analytic data for all service records and claims in Claim Review; Providers can choose to either view in a Chart or a Table the number of service records and claims currently in Claim Review.

1. From the View **as** tabs, click on the **Chart** tab to view a Chart report.

2. Click on the dropdown list arrow located in the top left corner of the Claims report, to select a time range for the report, i.e., Today, Yesterday, This week, Last week, This month, Last month, or Custom. Providers can also select Custom, which will allow them to configure custom start and end dates for the Claims report; use the dropdown list to select a date range, and then click the refresh icon, C, on the right.

3. Hover the cursor over any data point on the report to view a list of visits by status.

Claims Chart Report
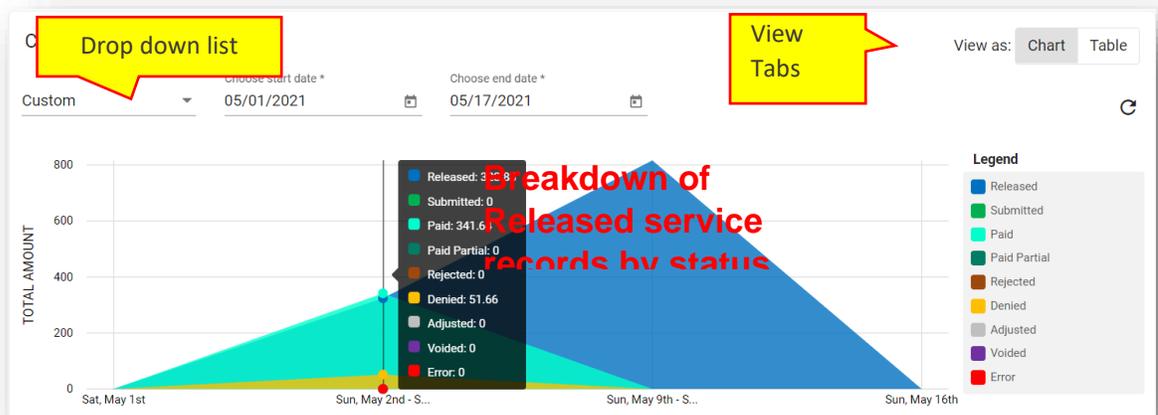
4. Click on the Chart to view the corresponding service records in Claim Review.

5. From the **View as** tab, click on the **Table** tab to view a Table report.

14

Claims Table Report

Claims

Drop down list

View Tabs

View as: Chart | Table

	Custom ▼	05/01/2021 📅	Choose end date * 05/17/2021 📅										C

Start Date	ACCEPTED	ADJUSTED	DENIED	ERROR	MATCHED	NEW	PAID	PAID PARTIAL	REJECTED	RELEASED	SUBMITTED	VOIDED	UNMATCHED
Saturday, May 1, 2021	0	0	0	0		0	0	0	0	0	0	0	0
Sunday, May 2, 2021	0	0	0	0		0	0	0	0	0	0	0	0
Monday, May 3, 2021	0	0	0	0		0	0	0	0	25	0	0	0
Tuesday, May 4, 2021	0	0	0	0		0	51.66	0	0	0	0	0	77.00999999999999
Wednesday, May 5, 2021	0	0	0	0		0	0	0	0	48.9	0	0	55.55
Thursday, May 6, 2021	0	51.66	0	244.06		0	289.98	0	0	249.98	0	0	63.86
Friday, May 7, 2021	0	0	0	0		0	0	0	0	0	0	0	0

Main Menu

You are here: Mobile Caregiver+ Claims Console > Viewing the Main Menu

The topics covered in this chapter is the Mobile Caregiver+ Claims Console menu options

Note: System Administrators have access rights to all menu options. Users assigned the "Billing" role will have restricted only access to the Claims Console menu options i.e., **Visits**, **Work Lists, Claim Review**, *and* **Prior Authorizations**.

The Main Menu icon, ☰, appears on the top left side of the Mobile Caregiver+ Claims Console. Click the **Main Menu** icon – sometimes called the "hamburger" icon to expand the menu and see a description of all options. Click it again to collapse the Main Menu so that just the icons are visible.

Main Menu Icon

16

Mobile Caregiver+ Claims Console Menu Options

The Main Menu provides access to all the features and functions of a Provider's Mobile Caregiver+ Portal. The menu options used for the Claims Console are listed in the table below:
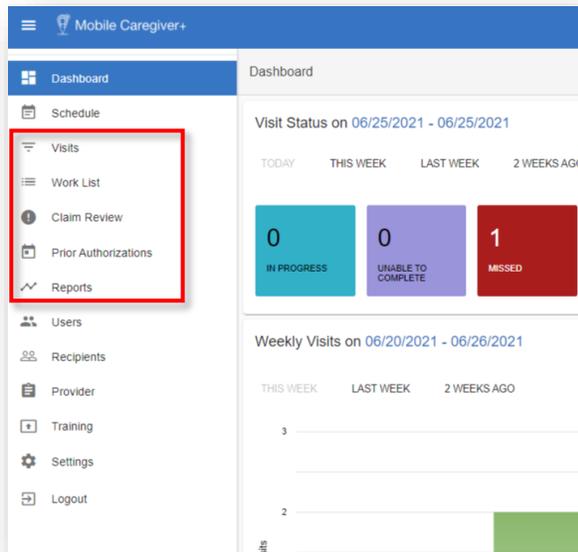
Menu Item	Description
Dashboard	Displays real-time and near-real-time EVV analytic data for scheduled visits.
Visits	Display all scheduled visits in a Provider's Mobile Caregiver+ Portal. The Visits menu option can be used to search for and to manage visits. The system will display all completed visits which have been completed using Mobile Caregiver+ as well as all visits sent from alternate EVV Systems.
Work List	Displays service records available to be processed and released for claims submission. The Work List menu option can be used to locate, review, remediate, and release services for claim submission.

Menu Item	Description
Claim Review	Displays a list chart, which depicts status and remittance data for all service records which have been released from the Work List. Providers will use the Claim Review menu option to obtain status and remittance data for released service records, as well as adjusting, void, and add Third Party Liability, EOB entries for Paid, and Partially Paid claims.
Prior Authorizations	Displays a list chart which depicts Prior Authorizations which have been added to a Provider's Mobile Caregiver+ Portal. Providers can use the Prior Authorization menu function to locate, and to review Prior Authorizations in their Provider EVV Portals. Depending on the Payer and Program, some Providers may be able to add and/or edit Prior Authorizations in their Provider Portals.
Reports	Displays a list of EVV Analytic Reports available in the Mobile Caregiver+ Provider Portal. Providers can use the Reports Menu Function to select, configure, run, and export reports from their Mobile Caregiver+ Portals.
Logout	Logs you out of the Mobile Caregiver+ Claims Console.

About Claims Processing

Providers schedule visits using their Netsmart or an alternate EVV System.

Providers can use the Visits menu option to view completed visits.

Completed services are processed and transferred to the Work List.

Service records transferred to the Work List are screened (pre-adjudicated) using "payer rules."

Screened service records are labeled:

- **Matched** – Service records that have no reported errors and can be released for remittance. Only Matched service records can be released for claims submission.

- **Unmatched** – Service records with reported errors that must be remediated and rescreened to change the status to Matched.

Provider Admins can review, select, and release Matched service records for claims submission.

Providers must remediate and re-screen Unmatched service records to change the statuses to Matched.

Released service records are moved to Claim Review.

Netsmart will submit all service records that have been released to the Payer.

Providers can check for status and remittance information in Claim Review.

A chart of the Netsmart claims workflow process is illustrated below.

Prior Auth Received	Visit Scheduled & Completed	Visit Data Captured by EVV System Sent to Netsmart	Mobile Caregiver+ System Pre-Adjudicates Claim	Provider Remediates or Releases Claim	Mobile Caregiver+ System Generates and Transmits Claim	Payer Adjudicates and Pays Claim
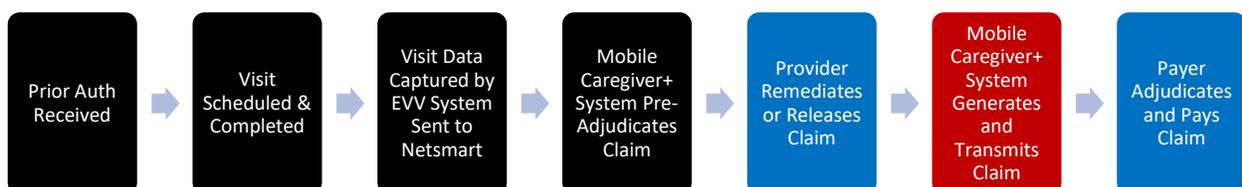
Claims Console Visits List

You are here: Mobile Caregiver+ Claims Console > The Visit List

Topics covered in this chapter:

- Managing the Visits List – Filtering and searching for completed visits

- Visits from Alternate EVV Systems

- Reviewing Visits to Claim Status

- Manually transferring missing service records to the Work List

- Search Visits to Claim Reconciliation

Providers can view completed visits in the Visits List.

Note: The Visit List is primarily used for trouble-shooting – 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.

Visits are scheduled and completed using either the Mobile Caregiver+ System or an alternate EVV System. Services completed during the visit will be processed and transferred to the Work List for claims processing by either of the two below systems:

- **Mobile Caregiver+:** Scheduled visits are completed using Mobile Caregiver+. Visit data is automatically stored in Providers' Mobile Caregiver+ Portal.

- **Alternate EVV:** Scheduled visits are completed using alternate EVV systems. Providers must send visit data to their Mobile Caregiver+ Provider Portals.

Note: Visit data sent from alternate EVV Systems will be screened and validated; visits missing or having incorrect data, i.e., incorrect Provider ID, Medicaid ID, etc. will be rejected.

Providers using alternate EVV Systems should consult their vendors on how to locate rejected visit data.

Managing the Visits List

You are here: Mobile Caregiver+ Claims Console > Claims Console Visits List> Managing the Visits List

Providers can use the Visits List to search for and filter completed visits in their Mobile Caregiver+ Provider Portals.

Providers can view completed visits in the Visits List.

Note: The Visit List is primarily used for trouble-shooting – 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.

Completed visits in the Visit List will have one of two statuses:

- Completed: Visit completed within the scheduled time will be labeled as Completed.

- Completed, Late: Visit completed after the scheduled end time will be labeled as Completed, Late.

To access the Visit List:

1. From the **Main Menu**, click **Visits,** ⇌ .

Providers can search and filter the Visits List by using the fields located in the header – Providers can filter the Visits list by entering/selecting one or more search parameters in one or more of the following fields:

Field Name	Filter Description
Payer	Allows Providers to filter the Visits list to only display visits scheduled for Recipients insured by the selected Payer. Providers must select a Payer to use the Search Visit to Claim Reconciliation function.
Recipient	Allows Providers to filter the Visits List by selecting one or more Recipients – The system will only display visits for the selected Recipient(s).
User	Allows Providers to filter the Visits list to only display visits scheduled for a selected User.
Visit ID	Each visit in the Mobile Caregiver+ Portal is assigned a unique 10-digit Visit ID; enter a Visit ID in the Visit ID field to search for a specific visit.
Visit Status	The Visit Status field displays the list of statuses for scheduled visits i.e., **IN PROGRESS, UNABLE TO COMPLETE, MISSED, NOT STARTED, LATE, IN PROGRESS, LATE, COMPLETED** and **COMPLETED, LATE**. Users can select a Visit Status to filter the Visits list to only display visits whose statuses match the selected status.
Visit Status Details	Display status information for visit from alternate EVV Systems. The system will display "**HOLD**" in the Visit Status Details field for visits that are not ready to be billed. The system is waiting for acknowledgement from the Alternate EVV System that the visit is completed.
Visits to Claim Status	The Visit to Claim Status field displays processing status for transferring service records to the Work List. The system will display **SUCCESS** for all billable services successfully processed and transferred to the Work List The system will display **ERROR** for service records not successfully transferred to the Work List. Users can select one of the two Visit to Claim Statuses to filter the Visits list to only display visits that match the selected status.
Start Date	Users can filter the Visits List to a specific range of visits based on the scheduled date of services. Providers can enter the **Start Date** in combination with an **End Date** to filter the Visits list by the specified range.

Field Name	Filter Description
End Date	Users can filter the Visits List to a specific range of visits based on the scheduled date of service. – Users must enter the **End Date** in combination with a **Start Date** to filter the Visits list by the specified range.
Search Visits	Users must click the blue **Search Visits** command to see the list of visits matching the search parameters – Users must click the blue Search Visit command to update the list after making any changes to the search parameters.
Search Visit to Claims Reconciliation	The **Search Visit to Claim Reconciliation** function is a tool which can be used to view status and remittance information for completed visits and service(s) completed in visits. Users must select a Payer to use the Visit to Claims Reconciliation function.

Note: Providers should check the Visit to Claims Status for service records that do not transfer to the Work List.

2. Enter any optional search parameter.

3. Click the blue **Search Visits** command to see a list of visits matching the search parameters.

Visits from Alternate EVV Systems

You are here: Mobile Caregiver+ Claims Console > Claims Console Visits List> Visits from Alternate EVV Systems

This information is only for Providers using Alternate EVV Systems.

Note: The Visit List is primarily used for trouble-shooting – The Mobile Caregiver+ Claims Console will automatically process and transfer service records from completed visits to the Work List for Claims Processing. Providers can use the Visits list to trouble-shoot missing service records.

For visits scheduled and completed in alternate EVV Systems, Providers must send visit data to their Mobile Caregiver+ Provider Portals.

Note: Visit data sent from alternate EVV Systems will be screened and validated; visits with missing or have incorrect data, i.e., incorrect Provider ID, Medicaid ID, etc. will be rejected.

For visits that are successfully imported from Alternate EVV System, the Mobile Caregiver+ Claims Console will automatically process and transfer service records to the Work List for claims processing.

To review the Visit to Claim Status for completed visits:

1. From the **Main Menu**, click **Visits,** ☰ .

2. Locate and review visits from Alternate EVV Systems

   Note: Review Alternate EVV System rejection report for missing visits.

The system will display "**HOLD**" in the Visit Status Details field for visits which are not ready to be billed.

Reviewing Visit to Claim Status

You are here: Mobile Caregiver+ Claims Console > Claims Console Visits List> Reviewing Visit to Claim Status

Providers can review the Visit to Claim Status to determine whether service records for completed visits were successfully transferred to the Work List.

Providers should review the Visit to Claim Status for any completed visit where the service record(s) do not transfer to the Work List.

To review the Visit to Claim Status for completed visits:

1. From the **Main Menu**, click **Visits,** ⩧ .

2. Locate visits and review the Visit to Claim Status field to locate any service records that were not successfully transferred to the Work List.

Manually Transferring Missing Service Records to the Work List

You are here: Mobile Caregiver+ Claims Console > The Visits List> Manually Transferring Missing Service Records to the Work List

Providers should review the Visit to Claim Status for any completed visit(s) where the service record(s) do not transfer to the Work List.

Providers can reprocess completed visit to regenerate and transfer service records to the Work List.

To review the Visit to Claim Status for completed visits:

1. From the **Main Menu**, click **Visits,** ₮ .

2. Locate and select one or more visits to reprocess.

3. Click on the cog icon, ⚙, located on right.

4. From the shortcut submenu, click **Re-Generate Claims**(s).

   Or

3. Provider Locate a visit to be reprocessed.

4. click on the **Actions** icon, ⋮, to view the **Visit Status Detail**.
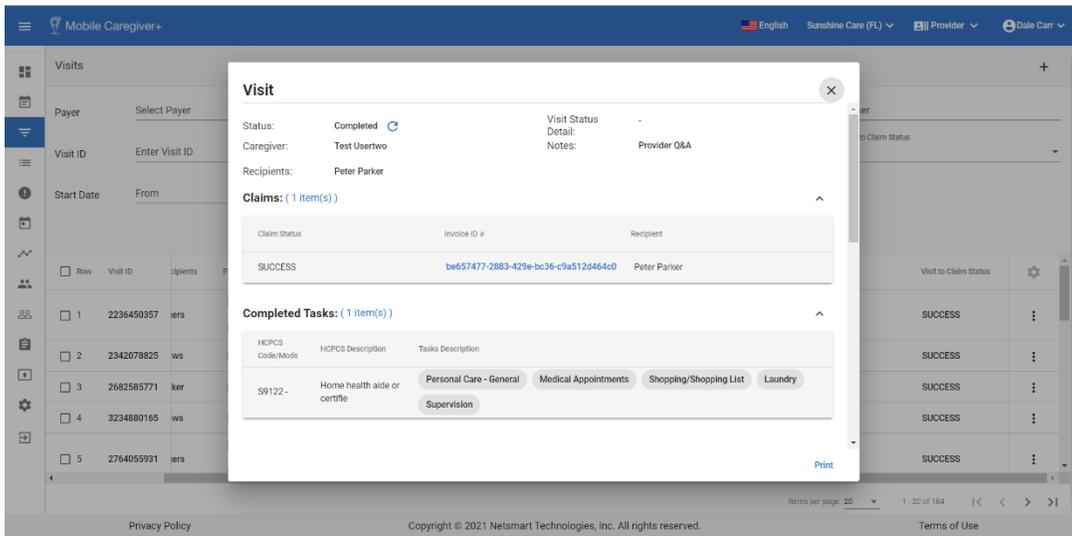
5. Click on the refresh icon, ↻, to regenerate the service record.

   Note: The system will display any reported error below the refresh icon. Please contact the Client Support Team for additional assistance.

Using Visit to Claim Reconciliation Tool

You are here: Mobile Caregiver+ Claims Console > Claims Console Visits List> Using Visit to Claim Reconciliation Tool

The Search Visit to Claim Reconciliation function is a "recon" tool which can be used to view status and remittance information for completed visit.

Provider can use the Search Visit to Claims Reconciliation function to view the status information for service(s) completed in visits.

Users must select a Payer to use the Visit to Claims Reconciliation function.

To use the Search Visit Claims Reconciliation function:

1. From the **Main Menu**, click **Visits,** ☰ **.**

2. Click in the **Payer** field and select a Payer.

3. Enter any additional filter parameter. For this example, we've entered a visit ID and chosen SUCCESS for the Visit to Claim Status.

4. Click the blue **Search Visit to Claim Reconciliation** command to view status information for the service records.

   Note: Two services were completed in this visit. Provider must adhere to their Payer's policies and Procedures when scheduling visits.

5. The system displays the service record(s) status(es) in the Visit Status field.

Note: Based on the status, Providers can determine whether service records are currently in the Work List or Claim Review, whether they have been paid, rejected, as well as any amounts that have been paid.

The Work List

You are here: Mobile Caregiver+ Claims Console > The Work List

Topics covered in this chapter:

- Managing the Work List

- Reviewing and Making Optional Edits to Matched Service Records

- Remediating Unmatched Service Records

- Releasing Matched Service Records for Claims Submission

- Adding Shared of Cost and Third-Party Liability to Service Records

- Archiving Service Records

Service records that are successfully processed for completed visits will be transferred to the Work List, where they will be screened (Matched) using Payer defined pre-adjudication rules.
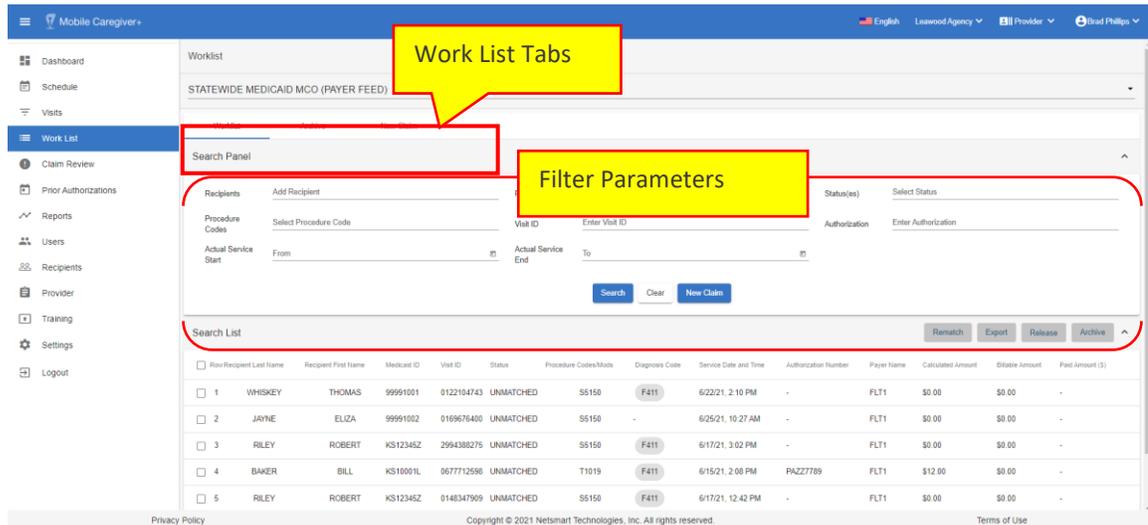
The Provider will use the Work List to locate, process, and release service records for claims submission.

Service records in the Work List will have one of five statuses:

- **New**: Services that are transferred to the Work List will have an initial status of New. When Providers edit Matched or Unmatched service records, the system will automatically set the status to New. New service records cannot be released from the Work List for claims submission.

- **Matched**: "Matched" service records are previously screened records that have no reported errors. Only Matched service records can be released from the Work List for Claims submission.

- **Unmatched**: "Unmatched" service records are previously screened service records that have reported errors. Unmatched service records cannot be release from the Work List for claims submission. Providers must remediate Unmatched service records to change their statuses to Matched.

- **Rejected**: "Rejected" service records are service records which were previously released for claims submission but were rejected and returned because of one or more technical error(s), such as missing and/or bad data. Providers must remediate

all reported errors and re-screen rejected service records to change their statuses to Matched.

- **Nack**: "Nack" service records are service records which were submitted to and rejected by a Payer for error(s). Providers must review and remediate all reported errors, then re-screen Nack service records to change their statuses to Matched.

  Note: The Mobile Caregiver+ Claims Console will screen service records on a recurring cycle; during scheduled screening cycles the system will automatically screen all service records that have a New or an Unmatched status.

Managing the Work List

You are here: Mobile Caregiver+ Claims Console > The Work List > Managing the Work List

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

Provider will use the Work List to locate, process, and release service records for claims submission.

To access, filter, and manage service records in the Work List:

1. From the **Main Menu**, click on **Work List**.
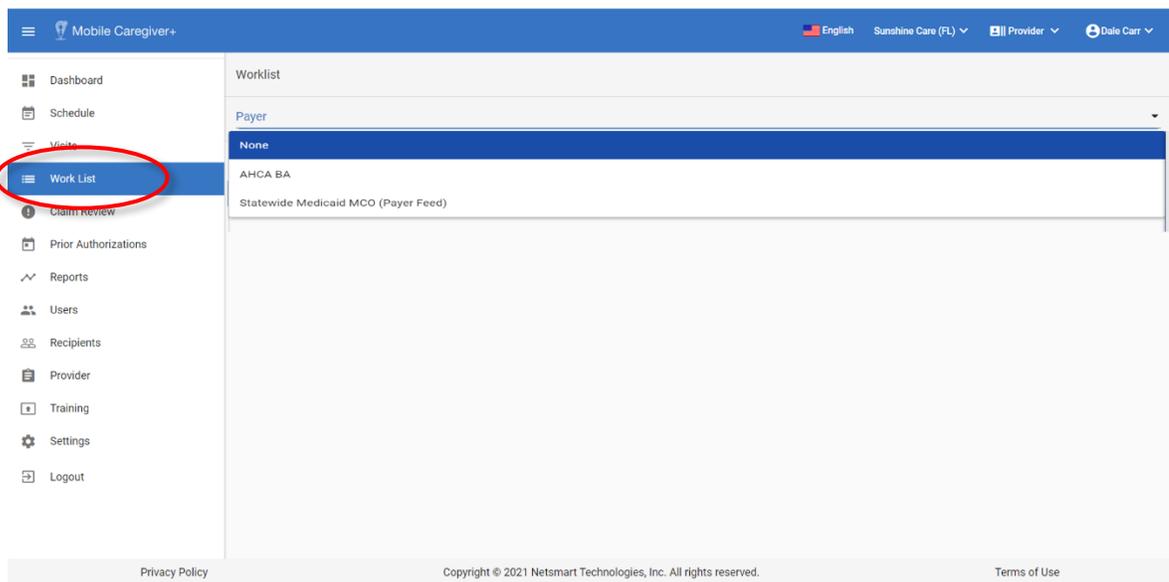
2. Click in the **Payer** field and select a Payer. Providers must select a Payer to display the Work List.

The Work List has is composed of three tabs:

- **Work List:** Displays all billable services that are successfully processed and transferred to the Work List. Providers will use the Work List to locate, manage, review, remediate, and release billable services for claims submission.

- **Archive:** The Archive is for "miscellaneous storage." Providers can archive and remove service records from the Work List. The Archive can be used to store "bad" service records that will not be release for claims submission i.e., duplicates, trial/training samples, etc.

- **New Claim:** The New Claims tab displays a form used to manually create service records. Providers can use the New Claim form to manually create services to be submitted as claims for unscheduled visits or to create new claims to appeal denied claims.
  Note: Unlike Rejected claims, which are returned to the Work List for remediation. Denied claims are not returned to the Provider's Mobile Caregiver+ Portal; Providers must use the New Claim function to manually create and submit a new service record in order to appeal a Denied claim.

Users can filter the list of service records displayed in the Work List by using the fields located in the header – Users can filter the Work List by entering/selecting one or more search parameters in one or more of the following fields:

Field Name	Filter Description
Payer	Users filter the Work List to only display service records for Recipients insured by a selected Payer. Users must select a Payer for the system to display the Work List.
Recipient	Users can filter the Work List by selecting one or more Recipients – The system will only display billable service records for the selected Recipient(s).
Payer ICN(s)	N/A – Billable service records are not assigned ICNs until they are accepted by Payers as claims.
Status(es)	Provider can filter the Work List by selecting one or more of the following statuses: New, Matched, Unmatched, and/or Rejected. The system will only display service records for the selected status(es).
Procedure Code	Providers can filter the Work List by selecting one or more Service Codes. The system will only display service records for the selected Procedure Code(s).
Visit ID	Each visit in a Provider's Mobile Caregiver+ Portal is assigned a unique 10-digit Visit ID number. Providers can enter a unique Visit ID to filter the Work List to only display the billable service(s) completed in the specified visit.
Authorization Number	Providers can enter a unique Authorization Number to filter the Work List to only display billable service(s) completed for the Recipient and the Service listed in the Prior Authorization.
Actual Service Start	Providers can filter the Work List to display a specific range of service records based on the reported start date and time – The Actual Service Start is the reported date and time recorded by the EVV device(s) used for completing services. Users must enter an Actual Service Start (From) date, in combination with an Actual Service End (To) date, to filter the Work List to display a list of services that one or more EVV devices reported as having been started in the specified date range.
Actual Service End	Providers can filter the Work List to display a specific range of service records based the reported end date and time – The Actual Service Start is the reported date and time recorded by the EVV device(s) used for completing services. Users must enter an Actual Service Start (From) date, in combination with an Actual Service End (To) date, in order to filter the to display a list of services that one or more EVV devices reported as having been started in the specified date range.

3. Enter any other optional search parameters.

4. Click the blue **Search** command to see a list of billable service records that match the search parameters.

Reviewing & Making Optional Edits to Matched Service Records

You are here: Mobile Caregiver+ Claims Console > The Work List > Reviewing & Making Optional Edits to Matched Service Records

Service records successfully processed for completed visits will be transferred to the Work List, where they will be screened (Matched) using Payer defined pre-adjudication rules. Service records with no reported errors will be labeled as Matched. Only Matched service records can be released for claims submission.

Note: It is recommended that Providers review Matched service records to ensure the accuracy of service records.

To review *Matched* Service Records:
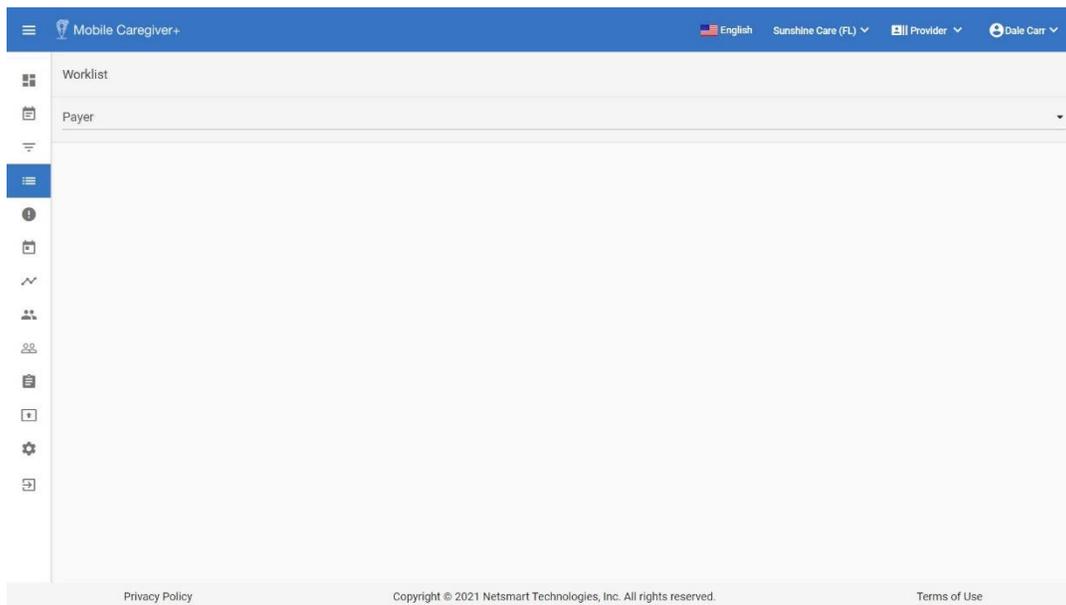
1. From the Main Menu click **Work List**, ≡ .

2. Click in the **Payer** field and select a Payer.

   Note: Providers must select a Payer to display the Work List.
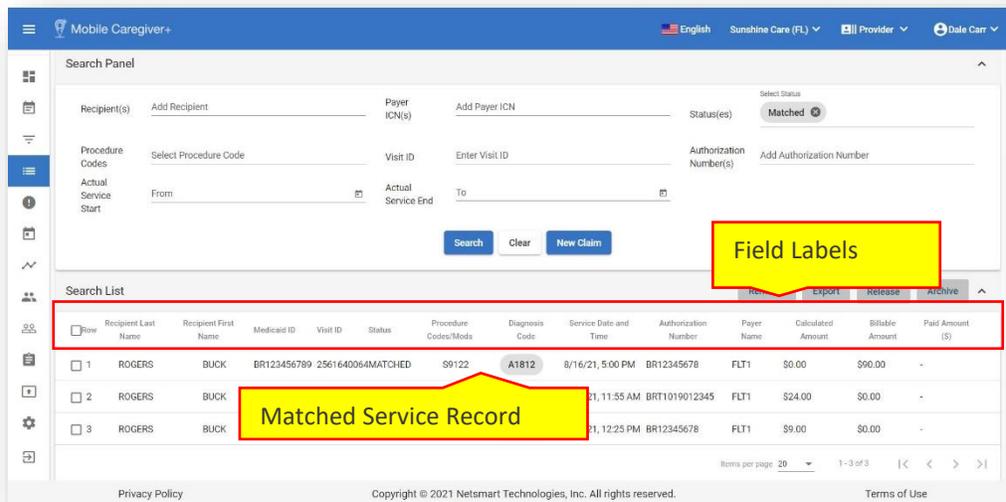
3. Optional – Click in the Status(es) field and select Matched (to display only Matched service records).

4. Enter any other optional search parameters.

5. Click the blue **Search** command to see a list of service records matching the search parameters.

   The Work List chart displays the following data:

Field Name	Filter Description
Recipient Last Name	Displays the Recipient's last name for each service record.
Recipient First Name	Displays the Recipient's first name for each service record.
Medicaid ID	Displays the Recipient's Medicaid ID.
Visit ID	Displays the unique ten-digit Netsmart ID that is assigned to the visit. If allowed by the Payer, services that are scheduled and completed in a single visit will have the same Visit ID.
Status	Displays screening, pre-adjudication, results for the service records, Matched, for records that have no reported errors, and Unmatched, for records that have reported errors.

Field Name	Filter Description
Procedure Codes/Mod	Displays the Procedure Code (Service Code) that is listed in the service record.
Diagnosis Code	Displays the Recipient's Diagnosis Code(s) that is listed in the service record. Most Payers require ICD-10 version Diagnosis Codes. *Note: The system will retain the billing sequence of Recipients' Diagnosis Codes as displayed in service records in the Work List; for claims submission, Diagnosis Codes will be submitted in the same order as they appear in the Work List.*
Service Date and Time	Displays the date and time values the EVV device recorded when the service was started.
Authorization Number	Displays the ID number that is assigned to the Authorization issued for the Recipient and service listed in the service record.
Payer	Displays the Name of the Payer the service will be submitted to.
Calculated Amount	Displays the estimated remittance amount the Provider will receive from the Payer for the rendered service. All Matched service records should display a Calculated Amount.
Billable Amount	Displays any manually adjusted remittance amount the Provider has entered. Billable field values will "over-ride" other values – Billable Values will be submitted to Payers.
Paid Amount	Displays the Remittance Amount that was issued for paid claims.

Note: The visits can be sorted by field label; Providers can click on a column header to sort the list by the field header.

6. Click on a Matched service record to view the service details.

Note: Providers can edit data in any field that displays an edit icon, ✎, a pencil. Providers can review and make edit to Matched service records, e.g., to update a non-ICD-10 Diagnosis Code or an incorrect Recipient or Provider Medicaid ID.

7. To edit the Diagnosis Code, click on the edit icon, ✎, located to the right of the Diagnosis Code field.

8. From the **Edit – Diagnosis Code** dialog box, click in the **Diagnosis Code** field to edit the current Diagnosis Code(s):

   - You can remove an existing diagnosis code by clicking on the "x."

   - You can add a new diagnosis code by clicking in the Diagnosis Code field and then start typing out the desired code.

   - You must select the correct ICD-10 Diagnosis Code from the drop-down list.

     Note: Providers can add one or more Diagnosis Code(s).

9. Click in the **Reason Code** field and select the most applicable reason for editing the field value.

   Note: The system will retain the billing sequence of Recipients' Diagnosis Codes as displayed in service records in the Work List; for claims submission, Diagnosis Codes will be submitted in the same order as they appear in the Work List, R69 ⊗ R54 ⊗ A009 ⊗ *.*

10. Enter any notes or comment in the **Notes** fields.

    Notes are mandatory for some edits; the Apply command will be remain inactive until Provider enters any required notes.

11. Click the blue **Apply** command to save the edits.

    - Providers should review service data including, but not limited to, the Actual Service Start, Actual Service End, Calculated Units, Calculated Amount, Provider's Medicaid ID, Recipient's Medicaid ID, Diagnosis Code(s), etc.

    - Make any other optional edits to Matched service record to ensure timely remittance.

    - Providers must update Recipient's EVV profile data in their Mobile Caregiver+ Provider Portal or their Alternate EVV System to ensure that the error does not recur.

12. Select and release Matched service records for claim submission.

Remediating Unmatched Service Records

Completed services are processed and transferred to the Work List.

Service records transferred to the Work List are screened (pre-adjudicated) using "payer-rules."

The system will display all errors that are detected when a service record is screened (pre-adjudicated) in the Edits & Error report, located in the bottom left corner of the service details screen. Providers must fix all reported errors to change the status of all Unmatched service records to Matched; the system will only allow Providers to release Matched service records for claims submission. When editing rendered service records, Providers are required to select Reason Codes to provide explanations for changing rendered service data. Depending on the Reason Codes selected, Providers may be required to enter mandatory notes providing additional details.

Note: Providers are not allowed to edit visit data recorded by EVV devices i.e., the Scheduled Visit Start, Actual Service Start/End, Start/End Verification Method, GPS Start/End Coordinates, etc.

Provider must make adjustments, remediations, by entering adjusted values in the "Billable" fields i.e., The Billable Service Start/End field are used to adjust the start and/or end time reported by the EVV device; the system will automatically calculate and post the Calculated Units and the Calculated Amount for which the claim will be submitted.

Depending on the Payer and Programs Recipients are enrolled with, some Providers may be able to make separate, and independent, adjustments for the number of units and the payment amounts that will be submitted for billable services. For more information and instructions, please refer to Manually Adjusting Billable Units and Billable Amounts for Claims.

Service records which are screened are either labeled as:

- **Matched** – Service records that have no reported errors.

- **Unmatched** – Service records that have reported errors that must be remediated and rescreened to change the status to Matched.

To locate and remediate Unmatched service records:
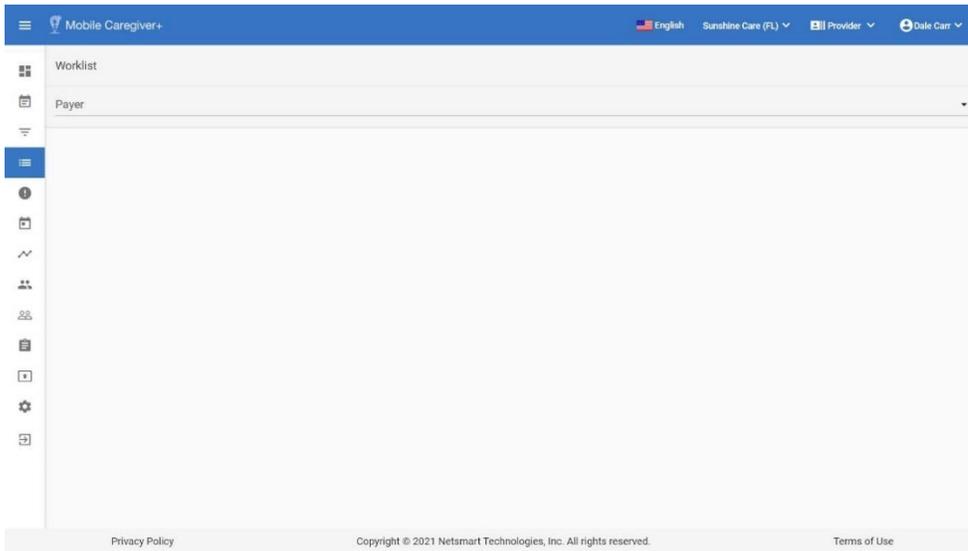
1. From the Main Menu click Work List, ☰ .

2. Click in the **Payer** field and select a Payer.

    Note: Providers must select a Payer to display the Work List.
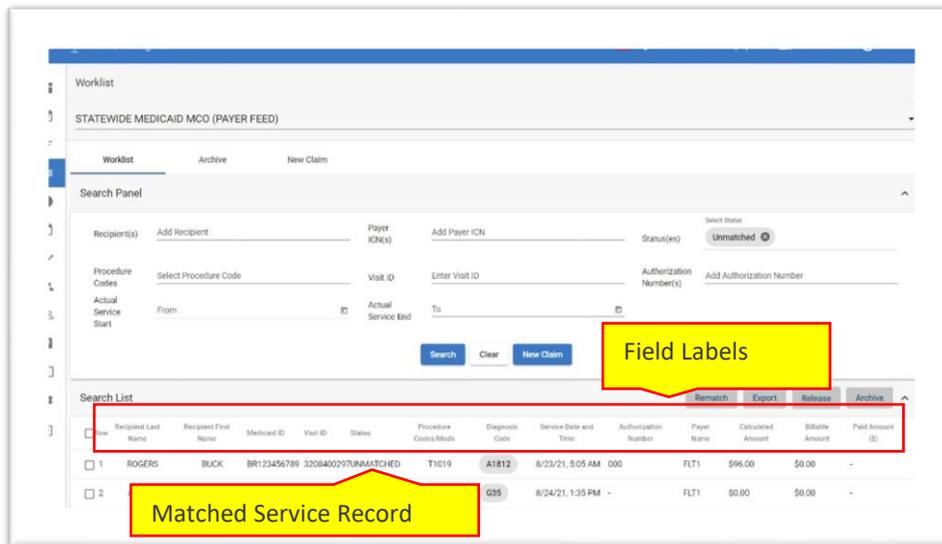
3. Optional – Click in the **Status(es)** field and select Unmatched (to display only Unmatched service records).

4. Enter any other optional search parameters.

5. Click the blue **Search** command to see a list of service records that match the search parameters.

6. Click on the Unmatched service record to view the service details.
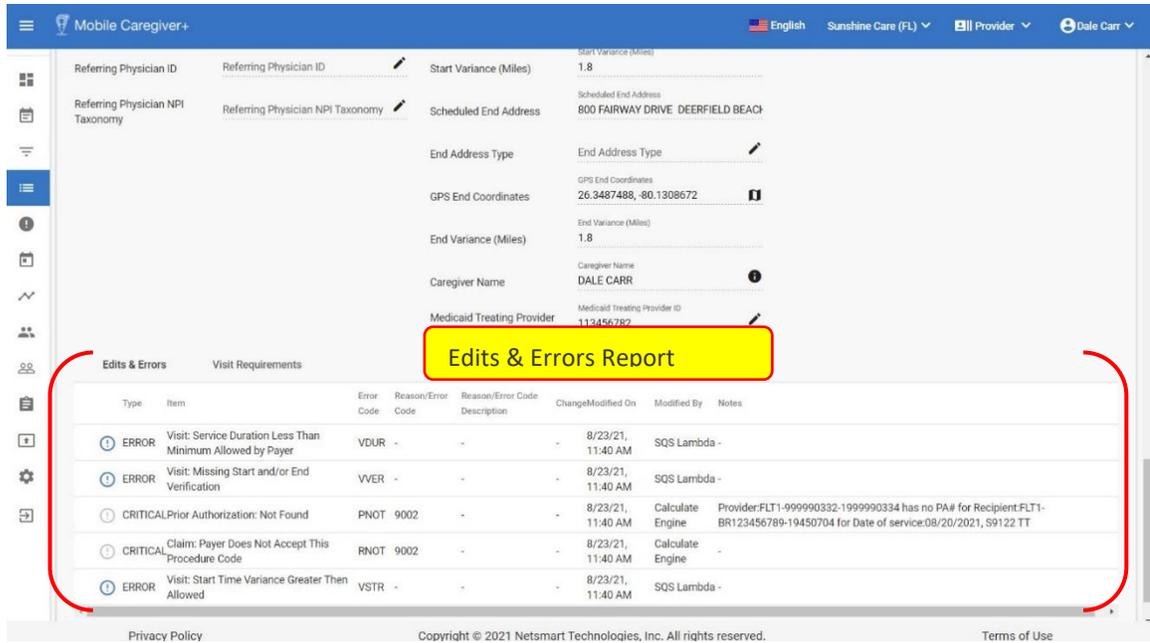
7. Remediate all reported errors.

    a. Visit: Start Time Variance Greater Than Allowed.

        i. Review data values in service details

Scheduled Visit Start is 4:00 AM.

Actual Service Start is 5:00 PM – Actual Service Start is the time the EVV device reported the service was started on the device.

Checked and confirmed that Caregiver was not able to see Recipient in the morning and did start service at 5:00 PM.

Provider cannot edit visit data values that are reported by EVV device; provide must edit Billable data values to make adjustment.

        ii. Review **Actual Start Time** and **Actual End Time** to see when service was started and ended.

Confirm what happened – Caregiver did start service later than allowed by Payer; you must clear the reported error by providing legitimate reason for the service being starting late.

        iii. Click on error message icon, ⊙.

iv. Click in **Reason Code** field and select the applicable Reason Code for the error.

v. Click in **Note** field and enter any applicable notes or comments.

vi. Click the blue **Apply** command to save the edits and clear the error message.

b. Visit: Missing Start and/or End Verification

i. Review data values in service details.

Start Verification Method	Start Verification Method PC	Data indicates that this visit was manually completed on a PC. Check and confirmed that Caregiver completed the service but did not use an EVV device.
End Verification Method	End Verification Method PC	
Actual Check-In Phone	Actual Check-In Phone	
Actual Check-Out Phone	Actual Check-Out Phone	

Confirm what happened – Caregiver did not use EVV device to record service; you must clear the reported error by providing the legitimate reason why the Caregiver did not use the EVV device.

ii. Click on error message icon, ⊙.
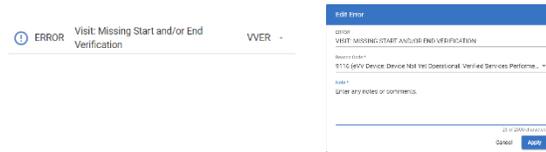
⊙ ERROR	Visit: Missing Start and/or End Verification	VVER ˅

Edit Error

ERROR
VISIT: MISSING START AND/OR END VERIFICATION

Reason Code*
9110 (#VV Device: Device Not Yet Operational. Verified Services Performe... ˅

Note *
Enter any notes or comments.

25 of 2000 characters

Cancel   **Apply**

iii. Click in **Reason Code** field and select the applicable Reason Code for the error.

iv. Click in **Note** field and enter any notes or comments.

v. Click the blue **Apply** command to save the edits and clear the error message.

*Note: The system will display the **Add Aggregator Edit Visit Reason Code** dialog box for Providers who submit claims to Payers that require custom Reason codes when users:*

- *Clear the **Visit: Missing Start and/or End Verification** error message in the Edits and Errors Report*

- *Edit the **Billable Start Time, Billable End Time, or Procedure Codes/Mods** field using the **Edit - Billable Time, Procedure Code/Modifiers, and/or Prior Auth.** dialog box.*

*When the users click the **'Apply'** button, the **Add Aggregator Edit Visit Reason Code** dialog box will be displayed to allows users to select a Payer defined visit reason code from a dropdown and enter notes for editing the rendered service data.*

*Disclaimer: The **Add Aggregator Edit Visit Reason Codes** dialog box is only applicable for Providers that use the Mobile Caregiver+ Claims Console to submit claims to Netsmart Designated Payers, where Netsmart is not the designated state aggregator, and the Payer requires custom Reason Codes for editing the respective rendered service data.*
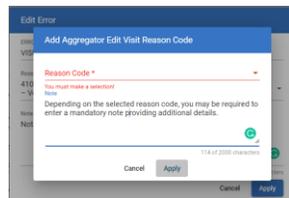
vi. Click in the **Reason Code** and select a reason that best explains why the service record is missing any start/end visit verification data.

*Note: Depending on the **Reason Code** you select, you may be required to enter a mandatory note to provide additional details.*

vii. Enter any notes or comments in the **Notes** field.

viii. Click the blue **Apply** command to save the data and close the dialog box.

c. Prior Authorization Not Found

i. Review data values in service details.

Procedure Codes/Mods	S9122 TT - - - ✏

Admin accidentally added a Modifier to the Procedure Code; confirmed that correct service was performed.

The Prior Authorization error message could also result from a Provider scheduling and completing a service before the Payer loads the approved "Auth" in the Mobile Caregiver+ Portal. This error would be cleared during the regular screening (Matching) cycle, once the Payer does load the Authorization.

Check to find cause of error; Prior Authorization not found error message can usually be remediated by adding a valid Authorization

47

*to the Provider portal or fixing an inaccurate service code. The
System will automatically clear error message when the service
record is rescreened during Matching cycle.*

ii. Click on the edit icon, ✎, for the **Procedure Code/Mods** field to edit
the service code.

*Note: The system will display the **Edit - Billable Time, Procedure
Code/Modifiers, and/or Prior Auth** dialog box, which allows you to
adjust one or more of the following:*

- Billable Start and the Billable End Times.

- Calculated Units and the Calculated Amount.

- Prior Authorization.

- Procedure Code/Mod for the claim.
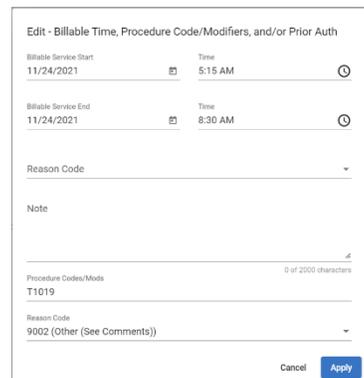
After the procedure code is
corrected to match the service code
listed in the Authorization, the
system will automatically clear the
Prior Authorization not Found Error
Message during the regular
screening (Matching) cycle.

The Administrator can also manually
rematch the service record demand.

iii. Click in the Procedure Code/Mods field and select the correct
service code.

iv. Click in the Reason Code field and select the applicable reason for
changing the procedure code.

v. Click in **Note** field and enter any notes or comments.

vi. Click the blue **Apply** command to save the change.

*Note: The system will display the **Add Aggregator Edit Visit Reason
Code** dialog box; the **Add Aggregator Edit Visit Reason Code** dialog
box allows you to select a Visit reason code from a dropdown and
enter notes (if applicable) for editing the rendered service data.*
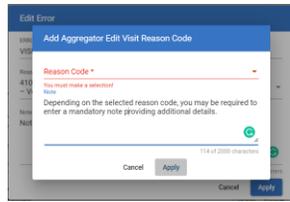
vii. Click in the **Reason Code** and select the reason for changing the procedure code.

*Note: Depending on the **Reason Code** you select, you may be required to enter a mandatory note to provide additional details.*

viii. Enter any notes or comments in the **Notes** field.

ix. Click the blue **Apply** command to save the data and close the dialog box.

d. Visit: Service Duration Less Than Minimum Allowed by Payer

i. Review data values in service details.

Actual Service Start is 5:00 PM – Actual Service Start is the time the EVV device reported the service was started on the device.

Actual Service Start is 5:05 PM

Provider Admin checked and confirmed that Caregiver worked from 5:00 PM to 8:00 PM, but accidently ended service on EVV device at 5:05.

ii. Review **Actual Start Time** and **Actual End Time** to see what time the EVV device reported the service started and ended.

iii. Click on the edit icon, ✎, to edit the **Billable Service Start** and/or the **Billable Service End**; you must use the Billable Service Start and/or the Billable Service End to adjust the start time and/or the end time for the service.
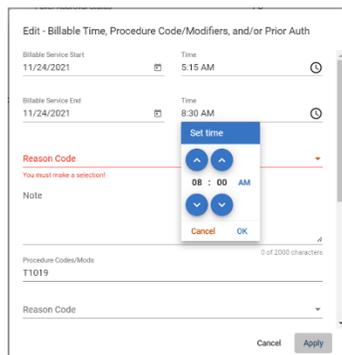
The system will automatically calculate and adjust the Calculated Units and the Calculated Amount to reflect any change to the Billable Start Time and/or the Billable End Time.

iv. Click on the clock icon, 🕐, and adjust the Billable Service Start and/or the Billable Service End times.

v. Click in the **Reason Code** field and select the applicable reason for making the adjustment.

vi. Enter any notes or comments in the **Notes** field.

vii. Click the blue **Apply** command to save the adjustment.

*Note: The system will display the **Add Aggregator Edit Visit Reason Code** dialog box; the **Add Aggregator Edit Visit Reason Code** dialog box allows you to select a Payer designated Visit reason code from a dropdown and enter notes (if applicable) for editing the rendered service data.*

*Disclaimer: The **Add Aggregator Edit Visit Reason Codes** dialog box is only applicable for Providers that use the Mobile Caregiver+ Claims Console to submit claims to Netsmart Designated Payers, where Netsmart is not the designated state aggregator, and the Payer requires custom Reason Codes for editing the respective rendered service data.*
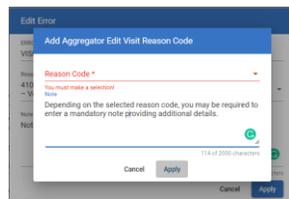
viii. Click in the **Reason Code** and select a reason for editing the start/end time for the service.

*Note: Depending on the **Reason Code** you select, you may be required to enter a mandatory note to provide additional details.*

ix. Enter any notes or comments in the **Notes** field.

x. Click the blue **Apply** command to save the data and close the dialog box.

xi. Scroll down to the **Edits & Errors** report to clear the error message.

xii. Click on error message icon, ⓘ.

xiii. Click in **Reason Code** field and select the applicable Reason Code for the error.

xiv. Click in **Note** field and enter any notes or comments.

xv. Click the blue **Apply** command to save the edits and clear the error message.

After remediating all reported errors, to rescreen the service record your user can:

- Manually rescreen (Match) individual service record by clicking the "**Recalculate Amount**" icon, ↻, located in the service details screen.

- Manually rescreen (Match) multiple service records by selecting one or more records from the Work List, then clicking the "**Rematch**," Rematch , command, locate in the Search List header.

- Do nothing and allow the system to rescreen (Match) the service record(s), during the regular screening cycle.

Manually Adjusting Billable Units and Billable Amounts for Claims

You are here: Mobile Caregiver+ Claims Console > The Work List > Manually adjusting Billable Units and Billable Units for Claims Submission

Depending on the Payer and Programs Recipients are enrolled with, some Providers may be able to manually adjust the number of units and the payment amounts for submitted claims. Providers can edit the Billable Units to manually enter the number of units they are requesting remittance for; Providers can also edit the Billable Amount field to manually enter the payment amount they are requesting.

For all claims where Providers have manually edited the Billable Units and Billable Amounts, the manually entered billable values will over-ride all other field values for claims submission – when the system generates claims, the billable values will take precedence over any other values. Billable values will be added to claims submitted to Payers.

To manually adjust Billable Units and Billable Amounts for claims submission:
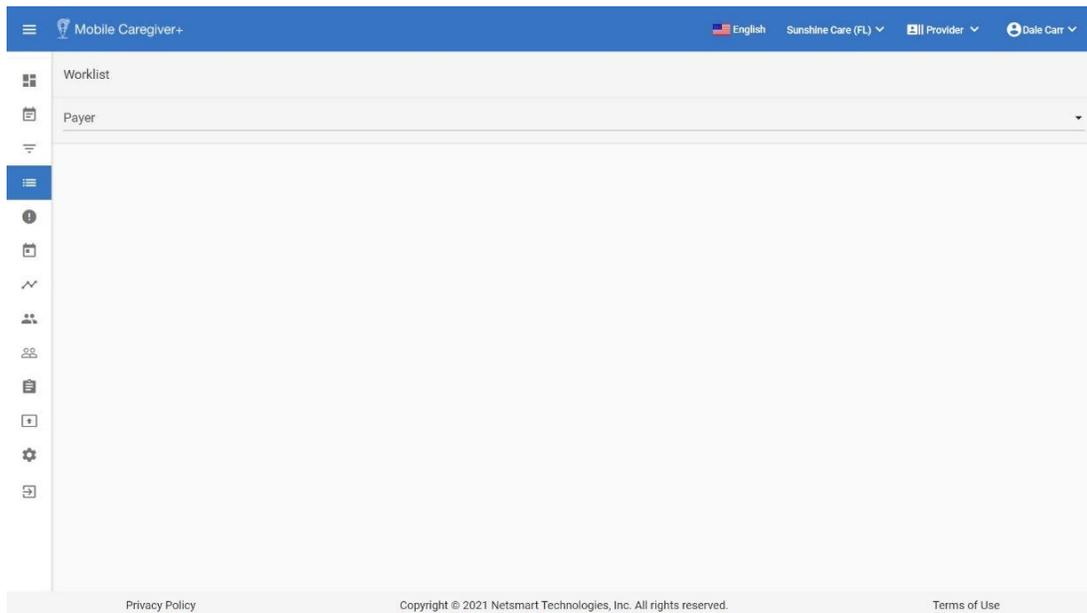
1. From the Main Menu click Work List, ☰ .

2. Click in the Payer field and select a Payer.

   *Note: Providers must select a Payer to display the Work List.*
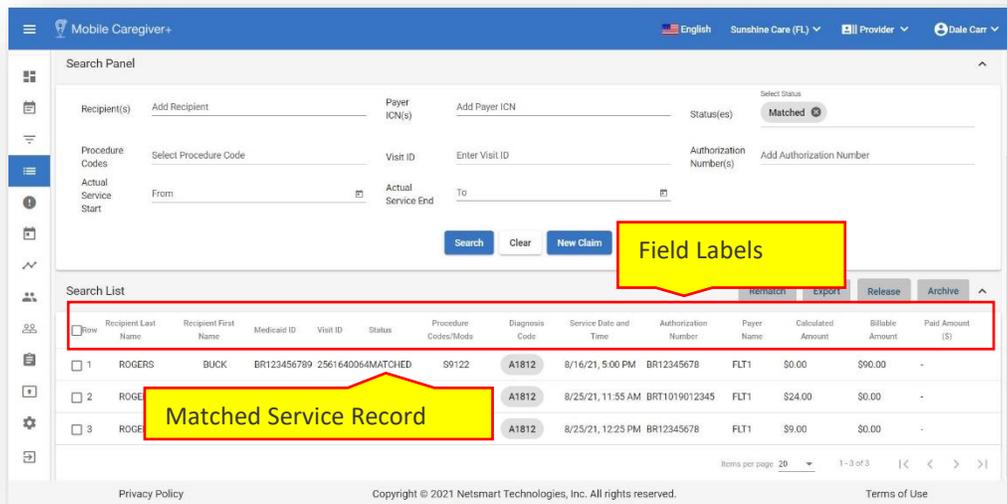
3. Enter any other optional search parameters.

4. Click the blue **Search** command to see a list of service records matching the search parameters.

5. Click on a service record to view the service details.

6. To manually enter the estimated number of units to bill for, click on the edit icon, ✏, located to the right of the **Billable Units** field.

7. From the **Edit – Billable Units** dialog box, click in the **Billable Units** field the exact number of units to bill for.

8. Click in the **Reason Code** field and select the most applicable reason for editing the field value.

9. Enter any notes or comment in the **Notes** fields.

10. Click the blue **Apply** command to save the edits.

11. To manually enter a custom estimated dollar amount to bill for, click on the edit icon, ✏, located to the right of the **Billable Amount** field.

12. From the **Edit – Billable Amount** dialog box, click in the **Billable Amount** field the exact dollar amount bill for.

13. Click in the **Reason Code** field and select the most applicable reason for editing the field value.

14. Enter any notes or comment in the **Notes** fields.

15. Click the blue **Apply** command to save the edits.

Note: For all claims where Providers have manually edited the Billable Units and Billable Amounts, the manually entered billable values will over-ride all other field values for claims submission – when the system generates claims, the billable values will take precedence over any other values. Billable values will be added to claims submitted to Payers.

Releasing Matched Service Records for Claims Submission

You are here: Mobile Caregiver+ Claims Console > The Work List > Releasing Matched Service Records for Claims Submission

Only Matched service records can be released for claims submission. Before releasing Matched service records for claims submission, Providers should review Matched service records and make any necessary corrections.

Warning: Providers submitting split-shift services, or any other situations where the same Caregiver renders the same service to the same Recipient multiple time times within the same day, must release all services for the day at the same time. For example, if a Provider reviews and release the morning service the same day the service occurs but forgets to review and release the afternoon service until the next day or later, the claim for the morning service will be paid, but the claim for the afternoon service that is submitted the next day will be denied as a duplicate.

To release Matched service records for claims submission:

1. From the Main Menu click Work List, ≡ .

2. Click in the **Payer** field and select a Payer.

   Note: Providers must select a Payer to display the Work List.
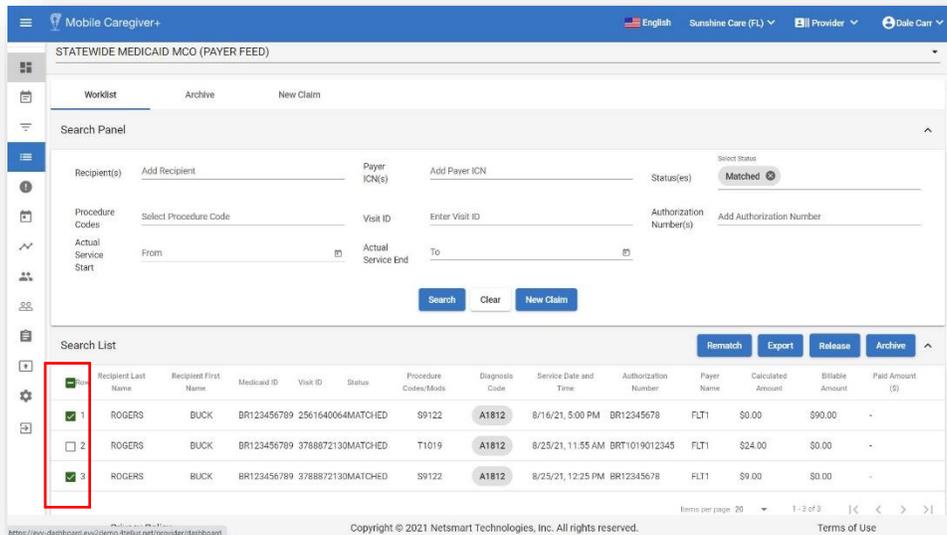
3. Optional – Click in the **Status(es)** field and select Matched (to display only Matched service records).

4. Enter any other optional search parameters.

5. Click the blue **Search** command to see a list of service records matching the search parameters.

6. Select one or more service records to be released; Provider can select all service records in the page by placing a checkmark in the checkbox row, located in the top left corner of the Search List.

7. Click the blue **Release** command.
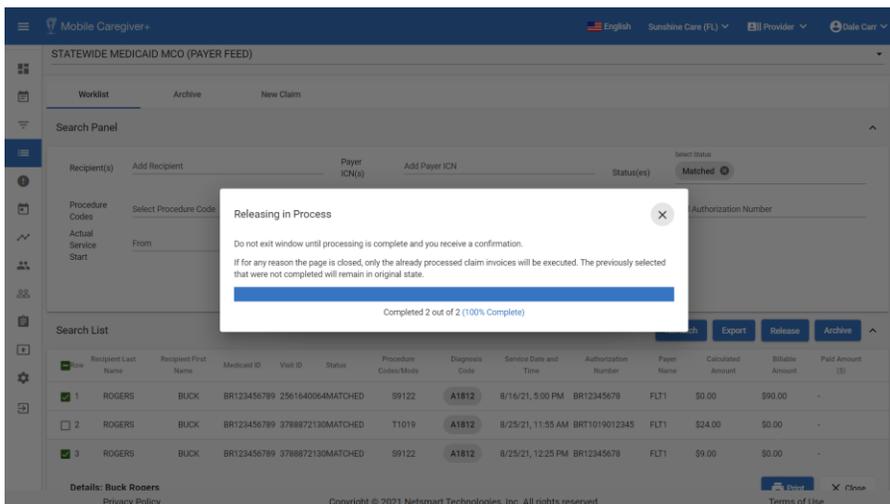
*****Warning**: For "split-shift service," where the same service is provided to the same Recipient multiple times within the same day, all rendered services being billed for the same day must be released together to avoid denial for duplicate claims.****

Wait until the progress meter in the Releasing in Process dialog box indicates that all service records have been release.

8. Click the close command, × , to close the Releasing in Process dialog box.
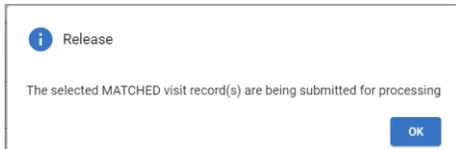
9. Click **OK** to close the Release confirmation dialog box.

Note: The system transfers all Released service records to Claim Review. Providers must use Claim Review to obtain status and remittance data for Released service records.

Adding Shared of Cost to Service Records
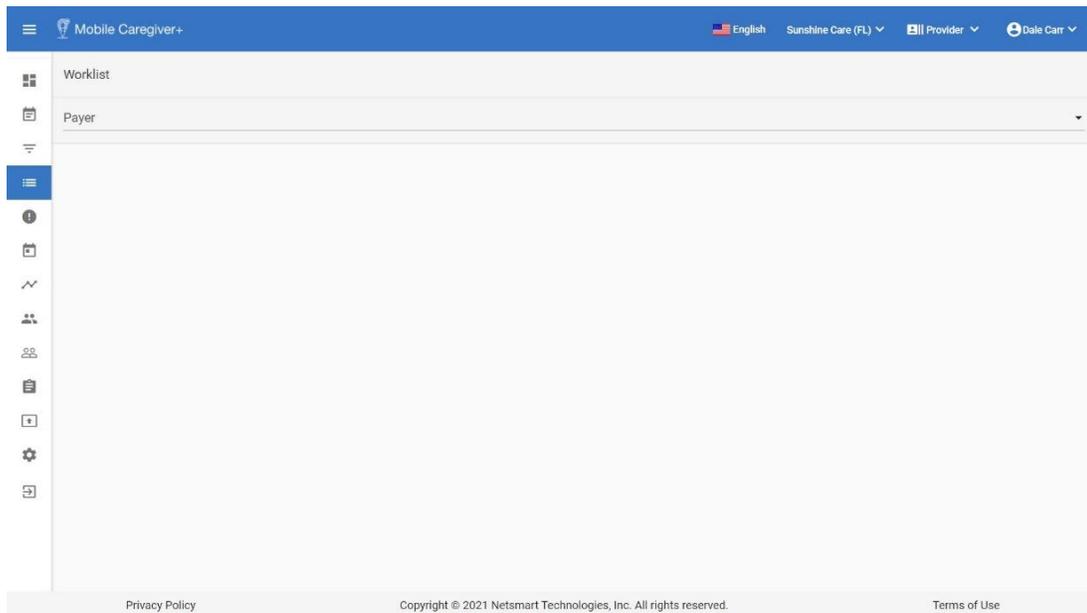
You are here: Mobile Caregiver+ Claims Console > The Work List > Adding shared of cost data to Service Records.

Some Recipients may be enrolled in a supplemental program commonly called "share of cost" (SOC), where the Recipient must pay a portion of their income each month before Medicaid is approved. Share of cost is similar to a deductible based on a Recipient's monthly income.

To add a new share of cost entry to a service record:

1. From the Main Menu click Work List, ☰ .
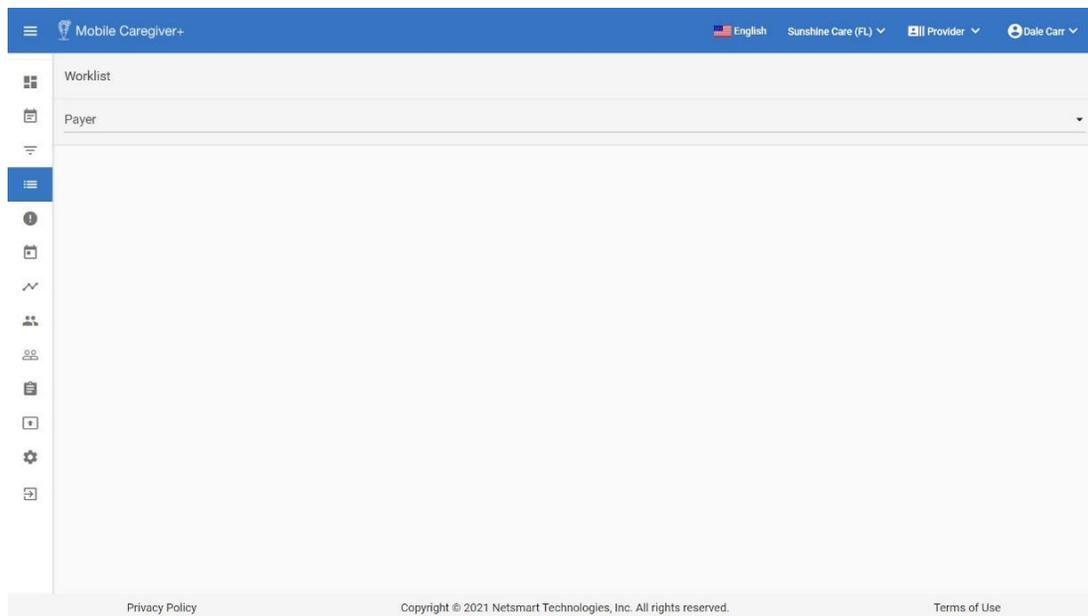
2. Click in the **Payer** field and select a Payer.

   Note: Providers must select a Payer to display the Work List.

3. Enter any other optional search parameters.

4. Click the blue **Search** command to see a list of service records that match the search parameters.

5. Locate and click on the service record you want to add the share of cost data to.

6. Click on the **Share of Cost** tab.

7. To add a new share of cost entry, click on blue **Add New SOC/TPS** command.

8. Enter the Recipient's payment information for the month in the Add SOC/TPL form:

    i. Click in the **Select Paid By** field and select Recipient Share of Cost.

    ii. Click in the **Paid Amount** field and enter the amount that the Recipient has paid.

9. Click the blue **Save** command to save and close the Add SOC/TPL form.

The Share of Cost entry will be added to the service record.

Editing Shared of Cost to Service Records

You are here: Mobile Caregiver+ Claims Console > The Work List > Editing Shared of Cost data in Service Record.

Some Recipients may be enrolled in a supplemental program commonly called "Share of Cost" (SOC), where the Recipient must pay a portion of their income each month before Medicaid is approved. Share of cost is similar to a deductible based on a Recipient's monthly income.

To edit an existing share of cost data entry in a service record:

1. From the Main Menu click Work List, ☰ .
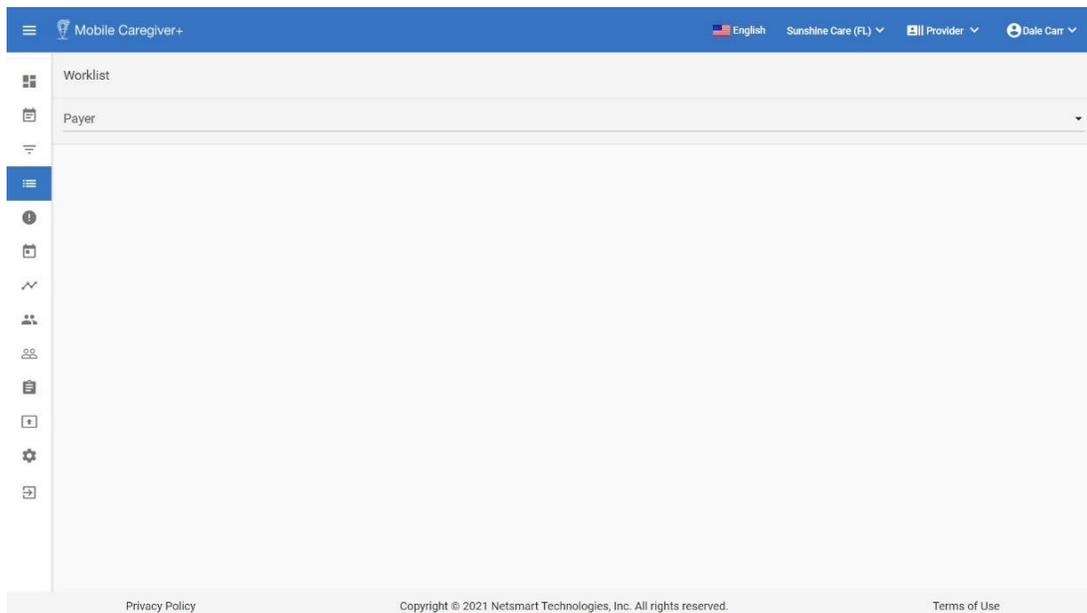
2. Click in the **Payer** field and select a Payer.

   Note: Providers must select a Payer to display the Work List.

3. Enter any other optional search parameters.

4. Click the blue **Search** command to see a list of service records that match the search parameters.

   Note: The system will display any existing SOC/TPL entry that has already been added to the service record – Please note that Providers must add SOC data to each individual service record.

5. Click on the Actions icon , ✎, for the existing SOC entry.

6. From the shortcut submenu, click **Edit**.

7. Edit the Paid Amount.

8. Click the blue **Save** command to save the changes and close the Edit SOC/TPL form.

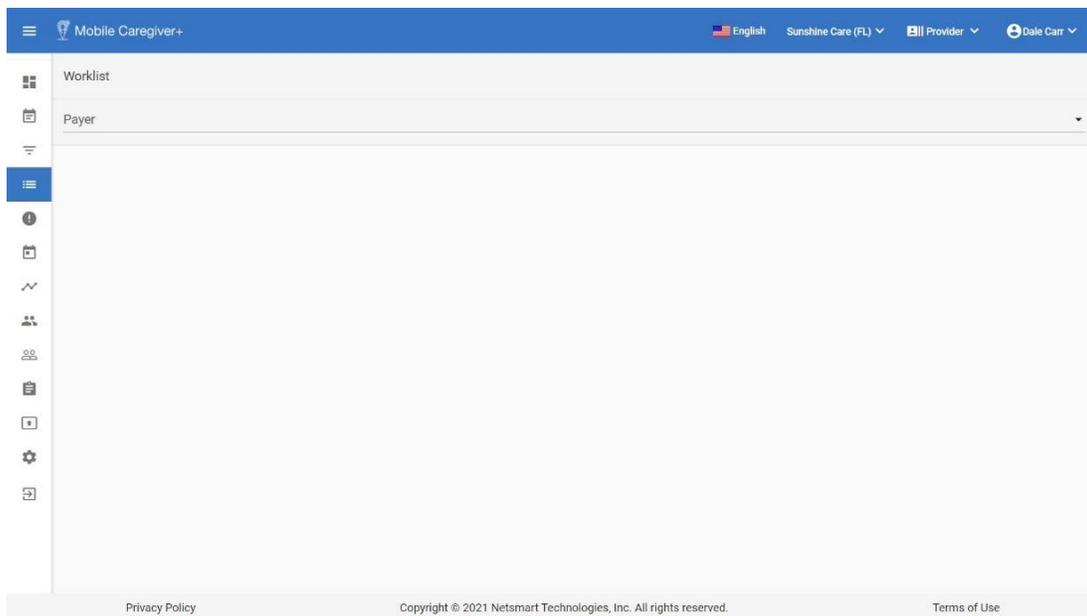## Adding Third-Party Liability for Paid and Partially Paid Claims to Service Records

You are here: Mobile Caregiver+ Claims Console > The Work List > Adding shared of cost data to Service Records.

Some Recipients may be enrolled with multiple insurance companies; Providers who submit claims to a Recipient's primary or secondary insurer, may want to submit the claim to another insurer for additional reimbursement. Providers can use the Add SOC/TPL function to add Third Party Liability (TPL) data for denied, paid, or partially paid claims.

For this exercise we will demonstrate how to add TPL data for a paid or partially paid claim.

To add a Third-Party Liability entry for a paid or partially paid claim:

1. From the Main Menu click Work List, ☰ .

2. Click in the **Payer** field and select a Payer.

   Note: Providers must select a Payer to display the Work List.

3. Enter any other optional search parameters.

4. Click the blue **Search** command to see a list of service records that match the search parameters.

5. Locate and click on the service record you want to add Third Party Liability (TPL) data to.

6. Click on the Share of Cost tab.

7. Click on blue **Add New SOC/TPL** command.

8. Enter the TPL data in the **Add SOC/TPL** form.

   For this exercise, you can look up the Insurer's information using the NPPES NPI Registry website.

   i. Enter the Payer's Name in the **Payer Name** field.

   ii. Click in the **Paid By** field and select whether the TPL data being entered is from a primary, secondary, or tertiary insurer.

   iii. Enter the Insurer's official NPI number in the **Payer ID Field**.

   iv. Enter the insurer's address in the **Payer Address** field.

   v. Enter the remittance date in the **Payer Paid Date** field.

   vi. Enter the date if a deductible was paid.

   vii. Enter amount of the deductible paid.

   viii. Enter the remittance amount in the **Paid Amount** field.

9. Click to blue **Save** command to save the TPL entry and close the Add SOC/TPL form.

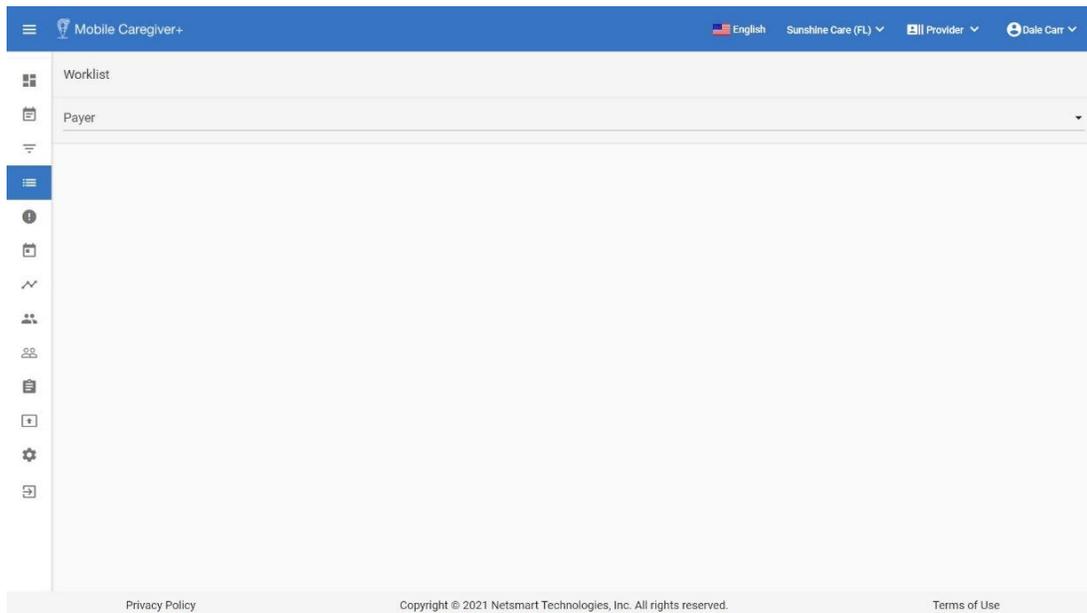## Adding Third-Party Liability for denied Claims to Service Records

You are here: Mobile Caregiver+ Claims Console > The Work List > Adding shared of cost data to Service Records.

Some Recipients may be enrolled with multiple insurance companies; Providers who submit claims to a Recipient's primary or secondary insurer, may want to submit the claim to another insurer for additional payment. Providers can use the Add SOC/TPL function to add Third Party Liability (TPL) data for a denied, paid or partially paid claim.

For this exercise we will demonstrate how to add TPL data for a denied claim.

To add a Third-Party Liability entry for a denied claim:

1. From the Main Menu click Work List, ☰ .

2. Click in the **Payer** field and select a Payer.

   Note: Providers must select a Payer to display the Work List.

3. Enter any other optional search parameters.

4. Click the blue **Search** command to see a list of service records that match the search parameters.

5. Locate and click on the service record you want to add Third Party Liability (TPL) data to.

6. Click on the **Share of Cost** tab.

7. To and a new TPL entry, click on blue **Add New SOC/TPS** command.

8. Enter the TPL data.

    For this exercise we will look up the Insurer's information using the NPPES NPI Registry website.

    i.   Enter the Payer's Name in the **Payer Name** field.

    ii.   Select TPL data being entered is for a primary, secondary, or tertiary insurer.

    iii. Enter the Insurer's official NPI number in the **Payer ID** Field.

    iv.   Enter the insurer's address in the **Payer Address** field.

    v.   Enter the denial date in the **Payer Paid Date** field.

    vi.   Enter the enter zero in the Paid amount field.

9. Click to blue **Save** command to save the TPL entry and close the Add SOC/TPL form.

Editing Third-Party Liability entries in Service Records

You are here: Mobile Caregiver+ Claims Console > The Work List > Editing shared of cost data in Service Records.

Some Recipients may be enrolled with multiple insurance companies; Providers who submit claims to a Recipient's primary or secondary insurer, may want to submit the claim to another insurer for additional payment. Providers can use the Add SOC/TPL function to add and edit Third Party Liability (TPL) data.

For this exercise we will demonstrate how to edit TPL data for a paid or partially paid claim.

To edit a Third-Party Liability data entry (Explanation of Benefits) for a paid or partially paid claim:

1. From the Main Menu click Work List, ≡ .

2. Click in the **Payer** field and select a Payer.

   Note: *Providers must select a Payer to display the Work List.*

3. Enter any other optional search parameters.

4. Click the blue **Search** command to see a list of service records that match the search parameters.

5. Click on the blue Add New SOC/TPL command.

   Note: The system will display any exist SOC/TPL entry that has already been added to the service record – Please note that Providers must add TPL data to each individual service record.

6. Click on the Actions icon, ✎, for the TPL entry.

7. From the shortcut submenu, click **Edit**.

For this exercise you can look up the Insurer's information using the __NPPES NPI__
__Registry__ website.

8. Edit the TPL data.

9. Click to blue **Save** command to save the TPL entry and close the Add SOC/TPL form.

Archiving Service Records

You are here: Mobile Caregiver+ Claims Console > The Work List > Archiving Service Records.

Providers can use the Archive to store duplicates and other types of "non-submittable" service records. The Archive is a "miscellaneous storage container" providers can use to remove (archive) "bad" service records from the Work List.

Warning: Providers should recover Medical Authorization Units from service records that are to be archived. This will ensure that the system maintains an accurate count of available units.

To archive service records from the Work List:

1. From the Main Menu click Work List, ☰ .

2. Click in the **Payer** field and select a Payer.

   Note: Providers must select a Payer to display the Work List.

73

3. Enter any other optional search parameters.

4. Click the blue **Search** command to see a list of service records that match the search parameters.

   Provider should recover Medical Authorization Units from service records that are to be archived; this will ensure that the system maintain an accurate count of available units.

   Providers can detach an Authorization from a service record in order to return the Medical Authorization Units to the Authorization.

   Use the following instructions to detach the Authorization from the service record to be archive:

5. Locate and click on the service record that is going to be archived (Provider can select and archive multiple service records simultaneously).

6. Click on the edit icon, ✎, for the Manual Override Auth No field.
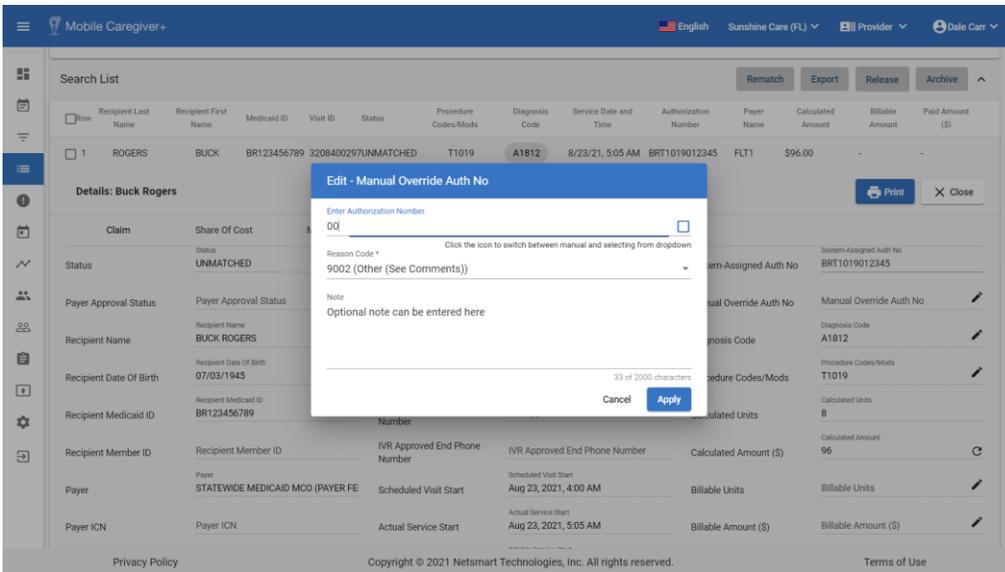
7. Enter zero in the **Authorization Number** field.

8. Click in the **Reason Code** field and select a reason.

9. Enter any optional notes or comments in the Note field.

10. Click the blue **Apply** command to save the changes and close the Edit – Manual Override Auth No dialog box. The system will return to the Search List.
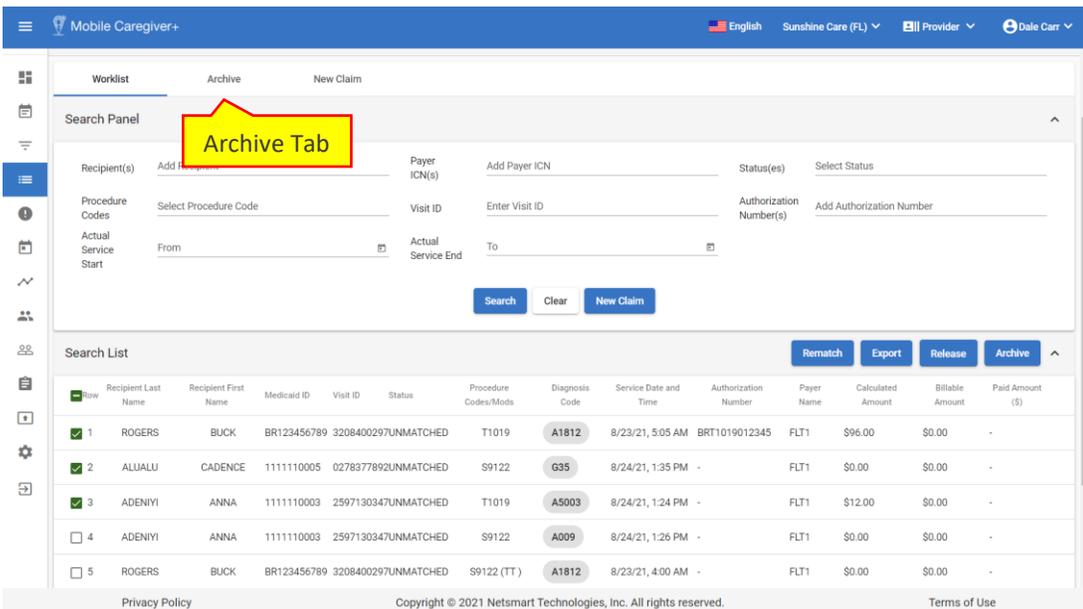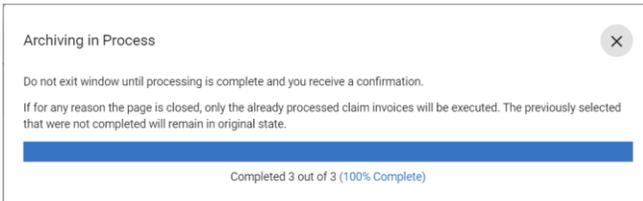

11. Select the service record(s) to be archived, then click the blue **Archive** command.
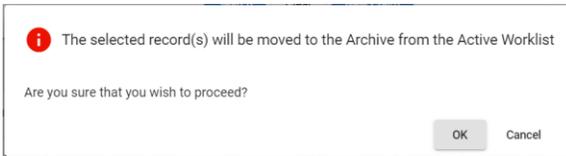
12. Click **OK** to close the confirmation dialog box.

13. Wait until the progress meter indicates that all service records have been moved to the archive.

14. Click the close command, ✕, to exit the Archiving in Process dialog box.

Restoring Archived Service Records

You are here: Mobile Caregiver+ Claims Console > The Work List > Restoring Archived Service Records.

Providers can use the Archive to store duplicates and other types of "non-submittable" service records. The Archive is a "miscellaneous storage container" that providers can use to remove (archive) "bad" service records from the Work List.

Providers will not be able to edit or release archived service records. Provider can restore service records, that were inadvertently archived, back to the Work List.

To restore archived service records back to the Work List:

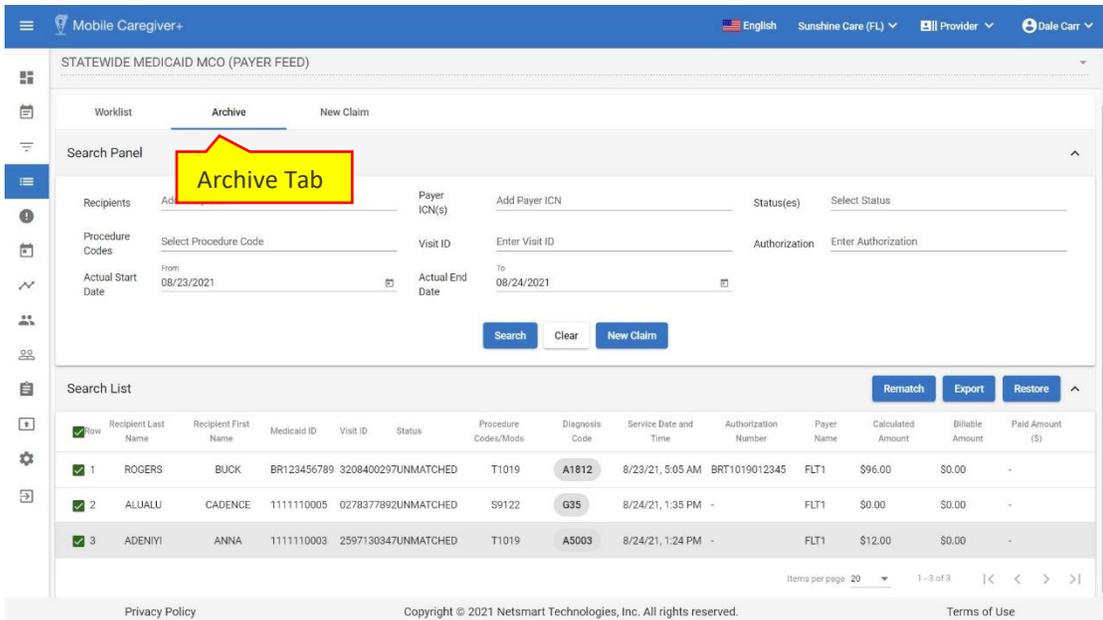1. From the Main Menu click Work List, ☰ .
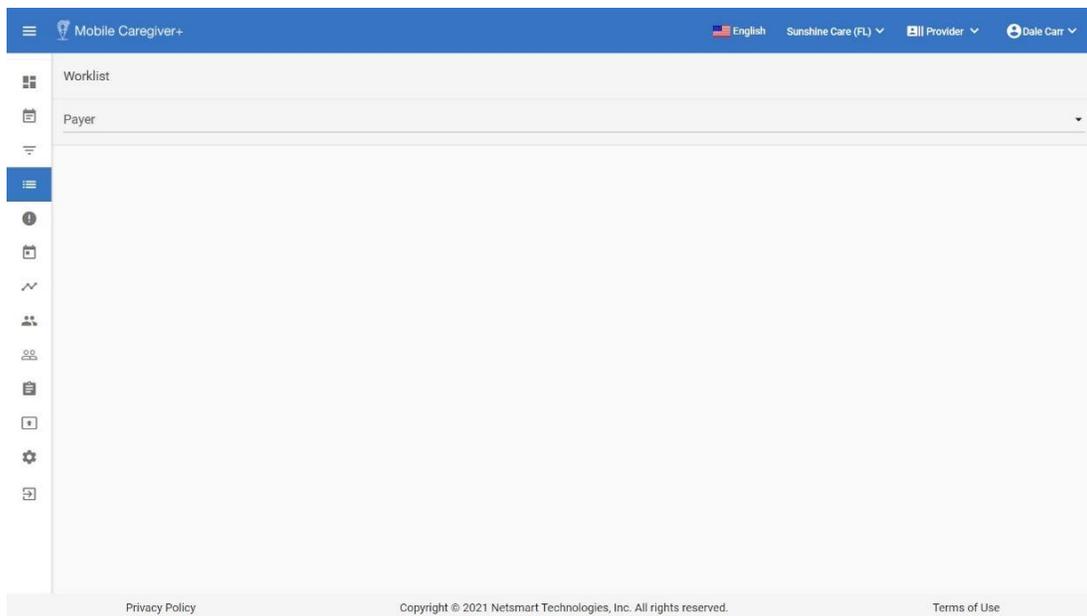
2. Click in the **Payer** field and select a Payer.

   Note: Providers must select a Payer to display the Work List.

3. Click on the **Archive** tab.

4. From the **Archive** tab, enter any optional search parameters.

5. Click the blue **Search** command to see a list of service records that match the search parameters.

   Use the following instructions to restore a service record back to the Work List:

6. Locate and select the service record(s) you want to restore.

7. Click the blue **Restore** command to transfer the selected service records back to the Work List.
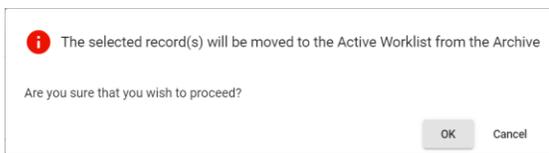
8. Click OK to close the confirmation dialog box.
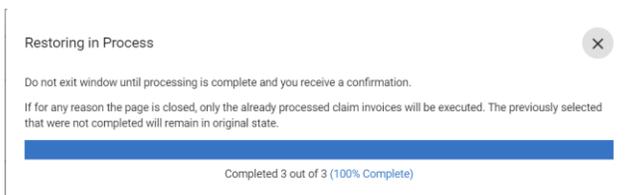
9. Wait until the progress meter indicates that all service records have been restored to the Work List.

10. Click the close command, ✕, to exit the Restoring in Process dialog box

Providers must manually relink Authorizations to the service records after restoring them from the Archive.

Use the following instructions to link an Authorization to a service record.

    i.   From the **Work List** tab, locate and click on the restored service record.

    ii.   Click on the edit icon, ✎, for the **Manual Override Auth No** field.

    iii.   Place checkmark in the checkbox located in the **Select Authorization** field.

    iv.   Click on the Authorization you want to link the service to.

    v.   Click in the **Reason Code** field and select the applicable reason.

    vi.   Enter any optional notes or comments in the Note field.
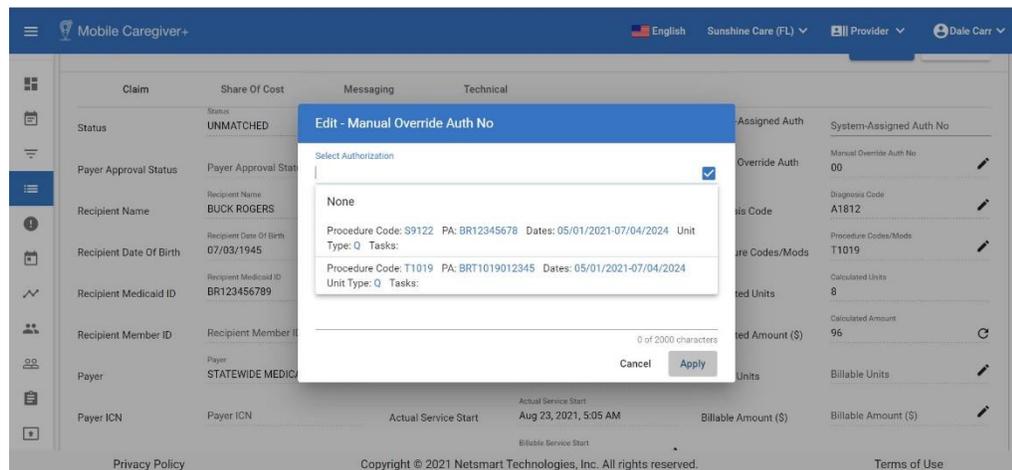
    vii.   Click the blue *Apply* command link the Authorization and close the **Edit – Manual Override Auth No dialog** box.

Manually Creating New Service Records

You are here: Mobile Caregiver+ Claims Console > The Work List > Manually Creating New Service Records.

Provider can use the New Claim function to manually create new service records to appeal denied claims and to submit EVV claims for unscheduled visits.

To create and transfer service record to the Work List:

1. From the Main Menu click Work List, ☰ .
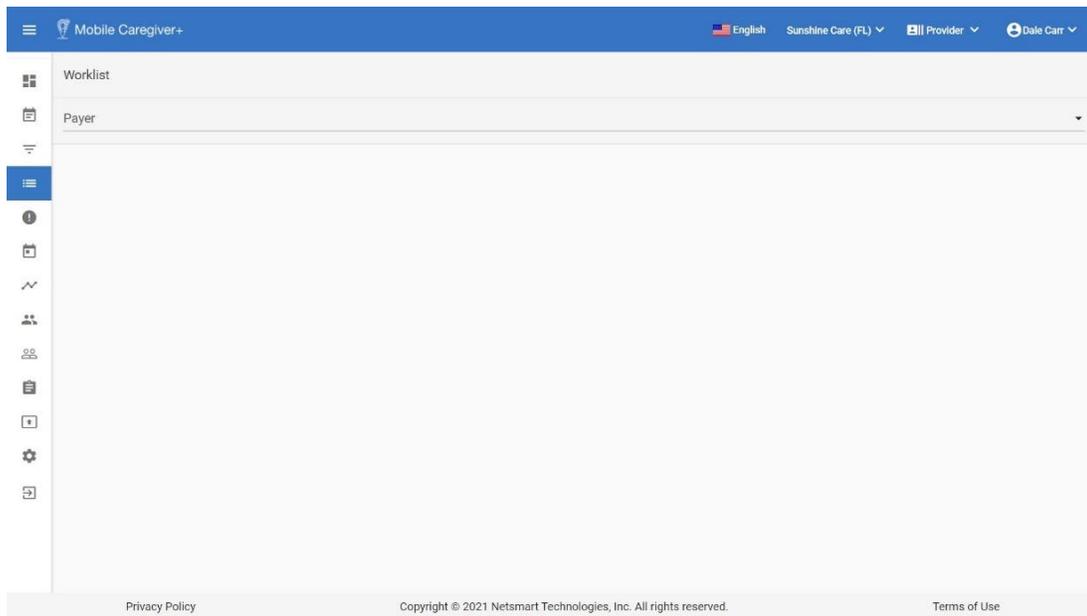
2. Click in the **Payer** field and select a Payer.

   *Note: Providers must select a Payer to display the Work List.*

New Claim Tab

3. After entering all service data, click the blue **Review** command.

4. Click on the **New Claim** tab

5. Enter the service data into the New Claim form.

   i. Click in the **Select Recipient** field and select the Recipient

   ii. Click in the **Procedure Code** field and select the Service Code; click in the Procedure Code Modifier field to add a modifier to the selected Service Code.

   iii. Click in the **Caregiver** field and select the Caregiver that completed the service.

   iv. Enter the Address where the service started.

   v. Enter the address where the service ended; you can click the blue circular button, with the arrow, to copy the start address as the end address.

   vi. Enter the date and time the service started.

   vii. Enter the date and time the service ended.
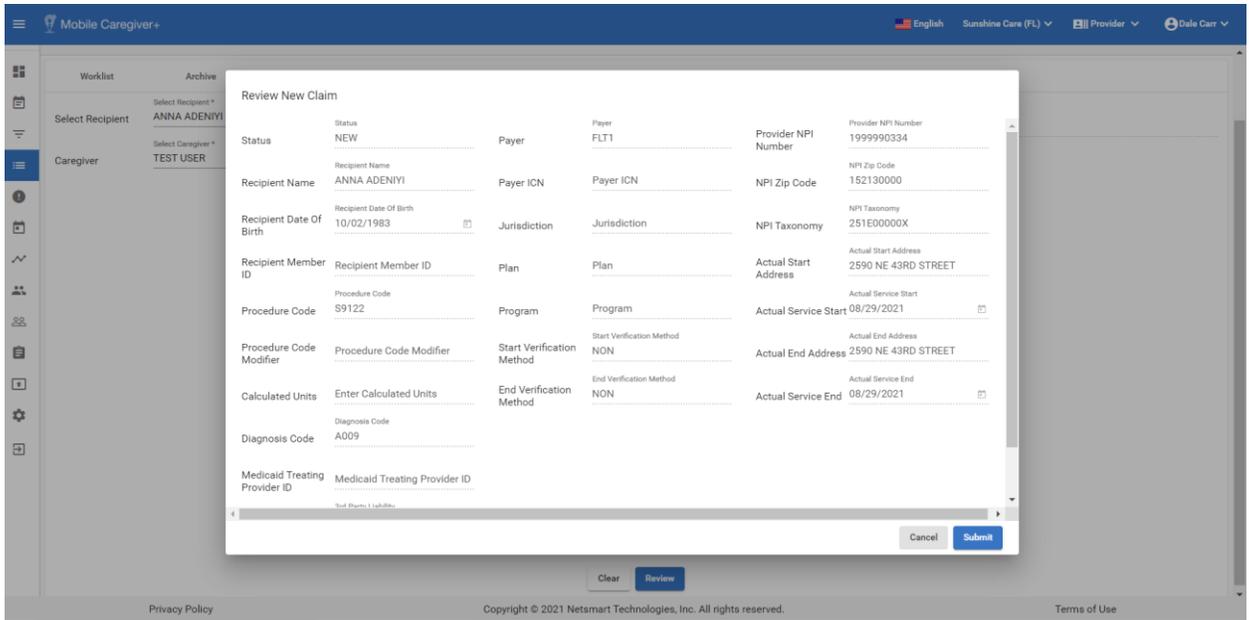
6. Review the service data and click the blue **Submit** command to create and transfer the service record to the Work List.

   Click Cancel to return to the New Claim form to edit the service data.
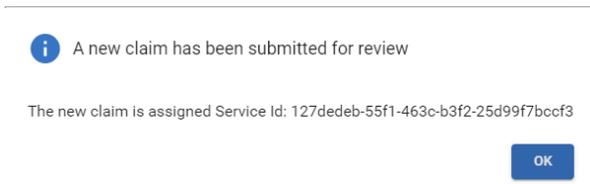
7. Click **OK** to save the service records and close the confirmation dialog box.

   The new service record will be transferred to the Work List, where it will be screened and labeled as Match or Unmatched.

Claim Review

You are here: > Claim Review

Topics covered in this chapter:

- Managing the Claim Review Search List

- Reviewing Status and Remittance Data for Released Service Records

- Locating and Remediating Rejected Claims

- Appealing Denied Claims

- Adjusting Paid and Partially Paid Claims

- Voiding Paid and Partially Paid Claims

Providers will use the Claim Review menu option to view status and remittance data for billable services that have been released from the Work List. In addition, Providers will use Claim Review to create and export remittance reports, as well as to void and adjust Paid and Partially Paid claims. The statuses of all billable service records that are released from the Work List will automatically be updated to Released. Released service records will be displayed in Claim Review.

Billable service records and claims displayed in Claim Review will have one of nine statuses:

- **Released**: Billable services that have been released from the Work List but have not yet been submitted to the Payer.

- **Submitted**: Billable services that have been submitted to the Payer.

- **Accepted**: Billable services that have been accepted by the Payer, which are then considered as claims to be reviewed for adjudication. Claim that are accepted by the Payers are assigned Internal Control Numbers (ICN) to be used for identification.

  *Note: In the Mobile Caregiver+ system, Medicaid, as well as some others, Payers will assign the same ICN to all claims submitted in a batch for a particular Recipient. You may have several claims with the same ICN; if any claim in the batch is adjusted and resubmitted, **all claims** with the same ICN must be resubmitted, including those that are not adjusted.*

- **Rejected**: Billable services that have technical errors, such as bad or missing data will be labeled as "Rejected;" Rejected service records are returned to the Mobile Caregiver+ Work List for remediation.

- **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.

  Note: Currently in the Mobile Caregiver+ System, Providers must manually create a new service record to resubmit for payment (appeal) for a denied claim.

- **Paid**: Claims that the Payer accepted, reviewed, and adjudicated to remit the full amount.

- **Paid Partial**: Claims that the Payer accepted, reviewed, and adjudicated to remit partial payment for. Providers may choose to adjust partially paid claims.

- **Adjusted**: Paid or Partially Paid claims that a Provider has edited (made changes to) and resubmitted for adjudication.

- **Voided**: Paid or Partially Paid claims for which a Provider has voided (reversed) payment.

Managing the Claim Review Search List

You are here: Mobile Caregiver+ Claims Console > Claim Review > Managing the Claim Review Search List

Providers will use the Claim Review menu option to view status and remittance data for billable services that have been released from the Work List.

To view status and remittance data for service records in Claim Review:

1. From the **Main Menu**, click on **Claim Review**.

2. Click in the **Payer** field and select a Payer (a Payer must be selected to proceed).

   Claim Review is composed of two tabs:

   - **Claims:** Displays status and remittance data for all service records that have been release from the Work List. Providers will use the Claims tab to check on the status of billable services that have been released for claims submission, review remittance data from Payer, and review any reported error for Rejected and/or Denied claims.

   - **Voids and Adjustment:** Providers will use the Voids and Adjustment tab to void and/or adjust Paid and Partially Paid claims. Providers will also use the Voids and Adjustment tab to view the list of claims that have been voided and/or adjusted.

85

Users can manage/filter the list of records in Claim Review by using the fields located in the header.

3. Filter the Search List by entering/selecting one or more search parameters in one or more of the following fields:

Field Name	Filter Description
Payer	Providers can select a Payer to filter the Claim Review list to only service records/claims for Recipients who are insured by the selected Payer. Providers must select a Payer to display status and remittance data for.
Payer ICN	Providers can enter an Internal Control Number to filter the Claim Review list to display on claims that have been assigned a designated ICN; Payers will assign an ICN number to claims once they have been accepted for payment adjudication.
Status(es)	Providers can filter the list of service records/claims by selecting one or more of the following statuses: Released, Submitted, Accepted, Rejected, Paid, Paid Partial, Denied. The system will only display service records for the selected status(es).
Procedure Code(s)	Providers can filter the list of service records in Claim Review by selecting one or more Service Codes. The system will only display service/claims for the selected Procedure Code(s).
Visit ID	Providers can enter a unique Visit ID to filter the list to display only billable service(s)/claim completed in the specified visit.
Authorization Number	Providers can enter a unique Authorization Number to filter the list of service records only display the billable service(s)/claims completed for the Recipient and the Service listed in the Prior Authorization.
Recipient	Providers can filter the list by selecting one or more Recipients – The system will only display service/claims records for the selected Recipient(s).
Member ID	Providers can enter a unique Member ID to filter the list to display only billable service(s)/claim completed for the specified member.

Field Name	Filter Description
Actual Start Date	Providers can filter Claim Review to display a specific range of service records, based the start date and time values the EVV device(s) reported for completed services. Providers must enter an Actual Service Start (From) date, in combination with an Actual Service End (To) date, to filter Claim Review to display a list of services that one or more EVV devices reported as having been started in the specified date range.
Actual End Date	Providers can filter the Work List to display a specific range of service records based the reported start date and time values from the EVV device(s) used for completed services. Providers must enter an Actual Service Start (From) date, in combination with an Actual Service End (To) date, to filter Claim Review to display a list of services that one or more EVV devices reported as having been started in the specified date range.

4. After entering all search parameters, click the blue **Search** command to see a list of service records that match the search parameter(s). Click the Clear command to clear all search parameters.

Reviewing Status and Remittance Data in Claim Review

You are here: Mobile Caregiver+ Claims Console > Claim Review > Reviewing Status and Remittance in Claim Review

Claim Review displays status and remittance data for all service records that have been released from the Work List. Providers will use Claim Review to check on the status of billable services that have been release for claims submission, review remittance data from Payer, and review any reported error for Rejected and/or Denied claims.

To view status and remittance data in Claim Review:

1. From the Main Menu, click Claim Review.

2. Click in the **Payer** field and select a Payer. You must select a Payer to continue.

3. Enter any other optional search parameters.

4. Click the blue **Search** command to display the list of claims and service records that match the search parameters.

   The Search List displays the following data:

Field Name	Description
Recipient Last Name	Displays the Recipient's last name for each record.
Recipient First Name	Displays the Recipient's first name for each record.

Field Name	Description
Visit ID	Displays the unique ten-digit Netsmart ID that is assigned to the visit. If allowed by the Payer, services that are scheduled and completed in a single visit, will have the same Visit ID.
Member ID	Displays the ID that the Payer has assigned to the Recipient.
Status	Displays the status of the service record or claim i.e., Released, Submitted, ACK, NACK Accepted, Rejected, Paid, Partially Paid, and/or Denied: • **Released** – Billable service record(s) that have been transferred to Claim Review to be transmitted to a Payer. • **Submitted** – Billable service records(s) that have been transmitted and are enroute to Payer. • **ACK** – Transmitted service records for confirmation has been received that the transmitted data has been received by the Payer. Service records waiting to be screened for acceptance for claims adjudication. • **NACK** – Transmitted service record(s) for which no confirmation has been received that the transmitted data has been received by the Payer. • **Accepted** – Billable service records that passed initial screening for technical errors and have become claims that await Payer adjudication for remittance. • **Rejected** – Billable service records that failed initial screening for technical errors and have been returned to the Claim Console, Work List for remediation and resubmission. • **Paid** – Adjudicated claims for which the Payer has paid the full amount for rendered services. • **Partially Paid** – Adjudicated claims for which the Payer has paid a partial amount for rendered services. • **Denied** – Adjudicated claims for which the Payer has denied (refused) payment.
Procedure Codes/Mod	Displays the Procedure Code (Service Code) that is listed in the service record or claim.

Field Name	Description
Diagnosis Code	Displays the Recipient's Diagnosis Code(s) that is listed in the service record or claim.
Service Date	Displays the date and time values the EVV device recorded when the service was started
Authorization Number	Displays the ID number that is assigned to the Authorization that has been issued for the Recipient and service listed in the service record.
Payer	Displays the Name of the Payer that the service will be submitted to.
Calculated Amount	Displays the estimated remittance amount the Provider will receive from the Payer for the rendered service.
Billable Amount	Displays any manually adjusted remittance amount the Provider has entered.
Paid Amount	Displays the Remittance Amount issued for paid claims.

5. Click on any record to view the service details.

Locating and Remediating Rejected/Nack Claims

You are here: Mobile Caregiver+ Claims Console > Claim Review > Locating and Remediating Rejected Claims

Claim Review displays status and remittance data for all service records that have been released from the Work List. Providers will use Claim Review to check on the status of billable services that have been release for claims submission, review remittance data from Payer, and review any reported error for Rejected and/or Denied claims.

Claims that have technical error i.e., incorrect Medicaid ID, invalid (non) ICD-10 Diagnosis Code, or any other missing or bad data will be rejected and returned to the Work List for remediation.

To locate Rejected claims in Claim Review:

1. From the Main Menu, click Claim Review.

2. Click in the **Payer** field and select a Payer. You must select a Payer to continue.

3. Click in the **Status(es)** field and select Rejected/Nack.

4. Enter any other optional filter parameter.

5. Click the blue **Search** command.

6. Locate and click on a Rejected service record to view the service details.

91

Rejected/Nack service records will be returned to the Work List. Providers cannot remediate rejected/Nack service records in the Work List.

Warning: Do not rematch and resubmit Rejected/Nack service records until you have corrected all reported errors. Service records that are rematched and resubmitted without remediation will be rejected.

Note: Providers using alternate EVV Systems can archive Rejected/Nack service records and use their alternate EVV system to create and submit new service records to appeal denied claims

7. Scroll down to the **Edits** and **Errors Report** to view reported errors.

8. Go to the **Work List** to remediate any reported errors.

9. From the **Main Menu**, click on **Work List**.

10. Click in the **Payer** field and select the Payer.

11. Click in the **Status(s)** field and select **Rejected/Nack**.

12. Click the blue **Search** command to see a list of Rejected service records that match the search parameters.

13. Click on a rejected service record to view the service details.

14. Remediate any errors that were reported for the rejected service record.

15. Rescreen and Release Matched service record.

Locating and Remediating Denied Claims

You are here: Mobile Caregiver+ Claims Console > Claim Review > Locating and Remediating Denied Claims

Claim Review displays status and remittance data for all service records that have been released from the Work List. Providers will use Claim Review to check on the status of billable services that have been release for claims submission, review remittance data from Payer, and review any reported error for Rejected and/or Denied claims.

Payers may Deny claims for duplication submission, untimely submission, etc.

Providers can use the Search List in Claim Review to locate, and review reported error for Denied claims. Denied claims are not returned to the Work List for Remediation; Provider must use the Work List to manually create new service records in to appeal Denied claims.

To locate and appeal Denied Claims in Claim Review:

1. From the Main Menu, click **Claim Review**.

2. Click in the **Payer** field and select a Payer. You must select a Payer to continue.

3. Click in the **Status(es)** field and select Denied.

4. Enter any other optional filter parameter.

5. Click the blue **Search** command.

6. Locate and click on a Denied claim to view the service details.

Note: Denied claims will not be returned to the Work List for remediation and resubmission.

Providers must use the New Claim function in the Work List to create new service records to appeal a denied claim.

Note: Providers using alternate EVV Systems can use their alternate EVV system to create and submit new service records to appeal denied claims.

7. Scroll down to the Edits and Errors Report to view reported errors.

8. From the **Main Menu**, click on **Work List**.

9. Click in the **Payer** field and select the Payer.

10. Click on the **New Claim** Tab.

11. Use the New Claim form to create a new service record to appeal the denied claim.

Adjusting Paid and Partially Paid Claims

You are here: Mobile Caregiver+ Claims Console > Claim Review > Adjusting Unpaid/Partially Paid Claims

Claim Review displays status and remittance data for all service records that have been released from the Work List. Providers will use Claim Review to check on the status of billable services that have been release for claims submission, review remittance data from Payer, and review any reported error for Rejected and/or Denied claims.

Providers will use Claim Review to locate, review, and adjust paid and partially paid claims. Only Paid and Partially Paid claims can be adjusted.

Note: The Mobile Caregiver+ Claims Console allows Providers to manually adjust the Billable Service Start and/or the Billable Service End Time(s) for Paid and Partially Paid claims – the system will automatically calculate and adjust the Billable Units and the Billable Amount values for all Paid and Partially Paid claims where Providers have adjust the Billable Start/End Time(s).

*Note: Medicaid, as well as some other Payers, assign the same ICN to all claims submitted in the same batch for a Recipient. You may have multiple claims with the same ICN; if any claim in a batch is adjusted and resubmitted, **all claims** with the same ICN must be resubmitted, including those that were not adjusted.*
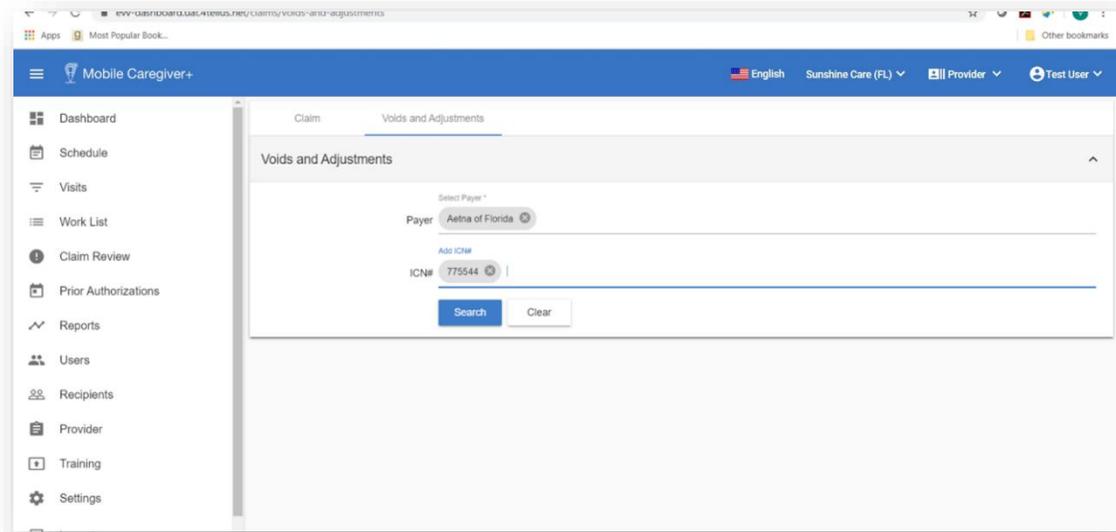
To adjust the **Billable Service Start** and/or the **Billable Service End** time for "Paid" or "Partially Paid" claims:
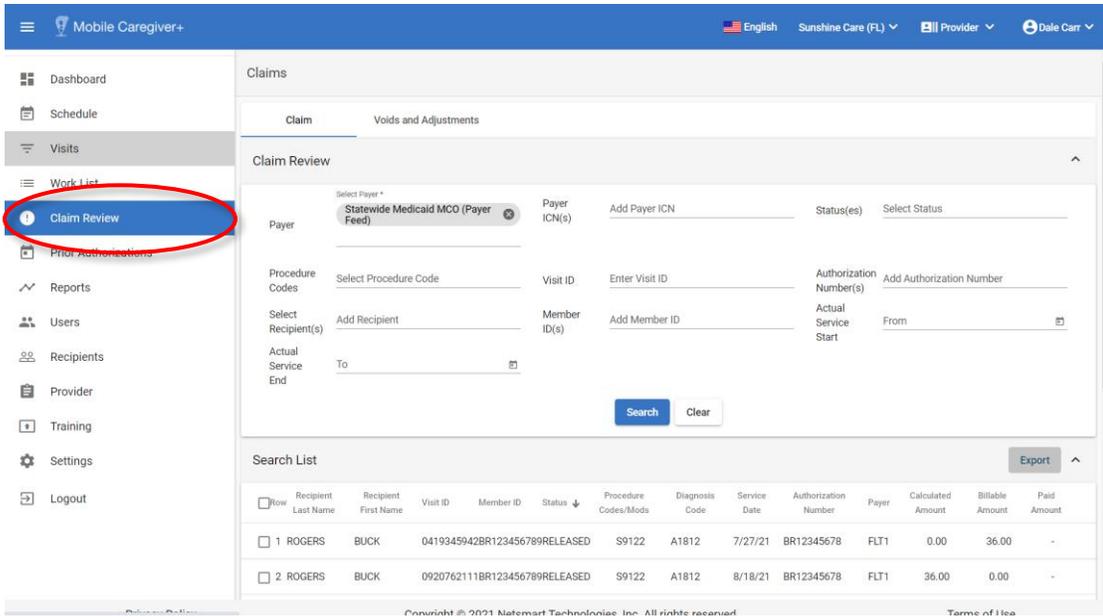
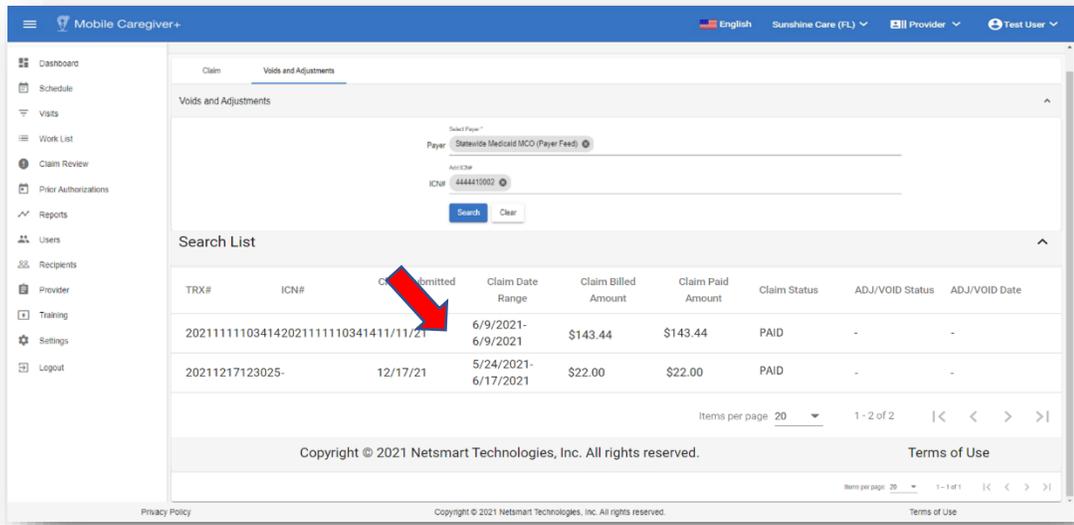1. From the Main Menu, click **Claim Review**.

2. Click in the **Payer** field and select a Payer.

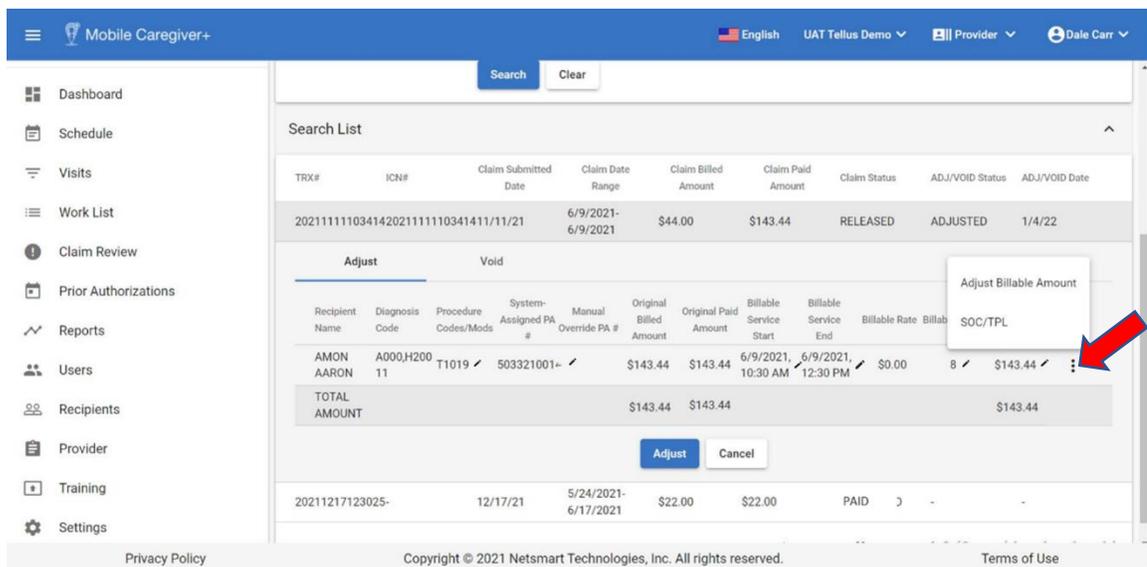3. Click the **Voids & Adjustments** tab.

4. From the **Voids and Adjustment** tab, click in the **Payer** field and select a Payer.

5. If you know the ICN, enter it in the ICN# field. You can copy the ICN number from the service details of the record on the claims tab.

6. Click the blue **Search** command.

7. Locate and click anywhere on the record of the claim you want to adjust, to view the details.

8. Click on the Action icon, ⋮, located to the right of the claim you want to adjust.

9. From the shortcut submenu, click *Edit - Billable Time, Procedure Code/Modifiers, and/or Prior Auth.*

   The system will display the *Edit - Billable Time, Procedure Code/Modifiers, and/or Prior Auth* dialog box, which allows you to adjust one or more of the following:

97

- Billable Start and the Billable End Times.

- Billable Units and the Billable Amount.

- Prior Authorization.

- Procedure Code/Mod for the claim.

*Note: The system will also display the **Edit - Billable Time, Procedure Code/Modifiers, and/or Prior Auth** dialog box if you click on the edit icon, ✎, for the **Procedure Codes/Mods, Manual Override PA, Billable Service Start** and/or the **Billable Service End** fields.*

Adjusting the Billable Service Start time and Billable Service End time:

i.   Click on the clock icon, 🕒, to adjust the **Billable Service Start** and/or the **Billable Service End** time(s).

ii.   Select a Reason Code.

iii.   You can also add text in the Note field to help clarify the reason for the change.

iv.   Click Apply to save the adjusted Billable Service Start and/or Billable Service End time(s).

Adjusting the Prior Authorization Number:

i.   Click on the checkbox in the **Select Authorization** field. The system will display all active Authorizations for the Recipient.

98

Edit - Billable Time, Procedure Code/Modifiers, and/or Prior Auth

04/04/2022   12:15 PM

Reason Code
9002 (Other (See Comments))

Note

Enter note here

16 of 2000 characters

Procedure Codes/Mods

S5150

S5150

S9124 A1 - - -

1113

S9122

Cancel   Apply

ii.   Select the Authorization you want to use.

iii.   You can also add text in the Note field to help clarify the reason for the change.

Adjusting the Service Code

i.   Click in the **Procedure Code/Mods** field. The system will display all active Authorizations for the Recipient.

Edit - Billable Time, Procedure Code/Modifiers, and/or Prior Auth

S9122

S9122 TT - - -

S9122 TT UF - -

S9122 TV - - -

S9122 UF - - -

Procedure Codes/Mods
s9122
You must make a selection!

Reason Code *

Note

Cancel   Apply

ii.   Select the service code you want to use.

iii.   You can also add text in the Note field to help clarify the reason for the change.

iv.   Click *Apply* to apply the service code the claim.

10. Click the blue **Adjust** after adjusting the line(s) that should be adjusted.

Click Cancel to exit the Adjust Claim window and return to the Voids and Adjustments Search List; all adjustment will be saved; providers can make review and/or make additional adjustments.
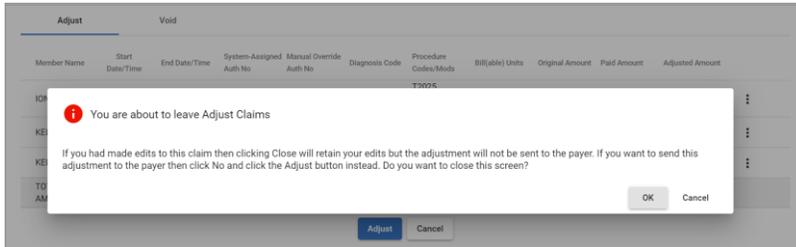
*Clicking **OK** will adjust and release the claim to be submitted to the Payer. Providers will not be able to make any further adjustment.*

11. Click **OK** to Release the adjusted claim for resubmission.

Manually Adjusting Billable Units/Billable Amount for Paid and Partially Paid Claims

You are here: Mobile Caregiver+ Claims Console > Claim Review > Manually Adjusting Billable Units and Billable Amount for Paid and Partially Paid Claims

Providers will use Claim Review to locate, review, and adjust paid and partially paid claims. Only Paid and Partially Paid claims can be adjusted.

Note: The Mobile Caregiver+ Claims Console allows Providers to manually adjust the Billable Units and/or the Billable Amounts, without changing the Billable Service Start and/or the Billable Service End Time(s), for Paid and Partially Paid Claims.

To Manually enter the Billable Units/Amount for "Paid" or "Partially Paid" claims:

1. From the Main Menu, click **Claim Review**.

2. Click in the **Payer** field and select a Payer.

3. Click the **Voids & Adjustments** tab.

4. From the **Voids and Adjustment** tab, click in the **Payer** field and select a Payer.

5. If you know the ICN, enter it in the **ICN#** field. You can copy the ICN number from the service details of the record on the claims tab.

6. Click the blue **Search** command.

7. Locate and click anywhere on the record of the claim you want to adjust to view the details.

8. Clicking on the edit icon, ✎, located to the right of the **Billable Units/Amount** field of the claim you want to adjust.

*Note: The Mobile Caregiver+ Claims Console allows Providers to manually adjust the Billable Units and/or the Billable Amounts, without changing the Billable Start/End Time(s), for Paid and Partially Paid Claims.*

9. Manually type in the units/amount you want to bill for the service.

10. Click in the **Reason Code** field and select a reason for adjusting the **Billable Units/Amount.**

11. Enter any optional note in the **Note** field.

12. Click the blue **Apply** command.

13. Click the blue **Adjust** after adjusting the line(s) that should be adjusted.

Click Cancel to exit the Adjust Claim window and return to the Voids and Adjustments Search List; all adjustment will be saved; providers can make review and/or make additional adjustments.
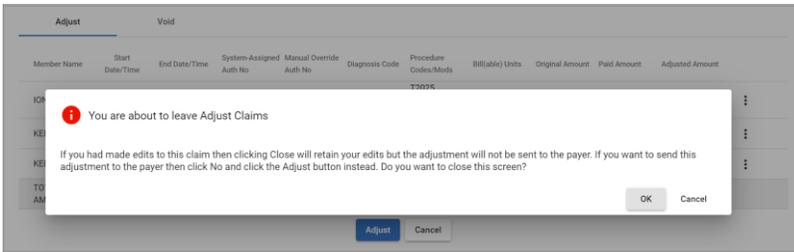
*Clicking **OK** will adjust and release the claim to be submitted to the Payer. Providers will not be able to make any further adjustment.*

14. Click **OK** to Release the adjusted claim for resubmission.

Voiding Paid and Partially Paid Claims

You are here: Mobile Caregiver+ Claims Console > Claim Review > Voiding Paid and Partially Paid Claims

Claim Review displays status and remittance data for all service records that have been released from the Work List. Providers will use Claim Review to check on the status of billable services that have been release for claims submission, review remittance data from Payer, and review any reported error for Rejected and/or Denied claims.

Providers will use Claim Review to locate, review, and void paid and partially paid claims. Only Paid and Partially Paid claims can be adjusted.

Medicaid, as well as some other Payers, assign the same ICN to all claims submitted in the same batch. Voiding a claim will void all lines in the claim. The system will void all claims that have the same ICN.
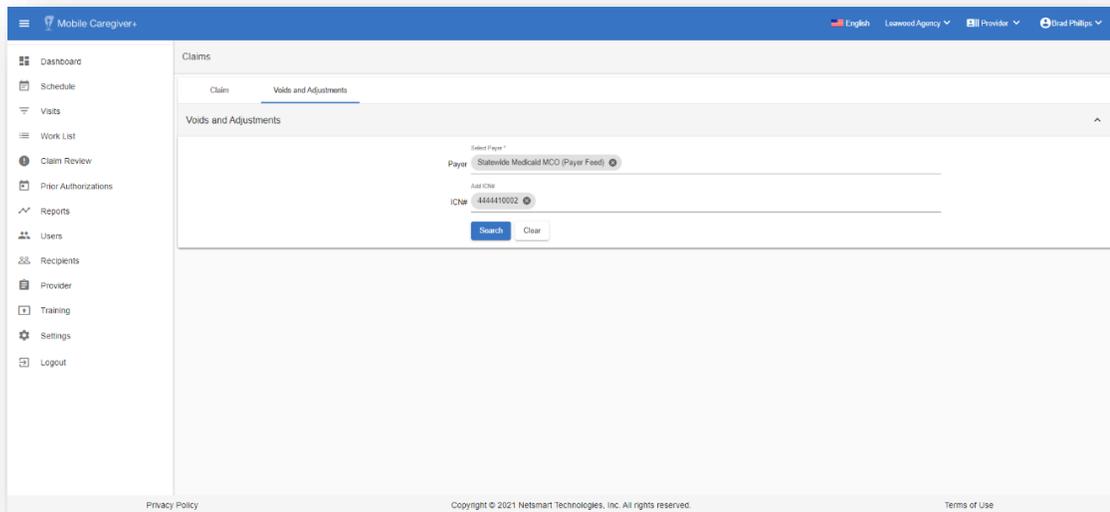
To Void a "Paid" or "Partially Paid" claim:

1. From the Main Menu, click **Claim Review**.

2. Click in the **Payer** field and select a Payer.

3. Click the **Voids & Adjustments** tab.

4. From the **Voids and Adjustment** tab, click in the **Payer** field and select a Payer.

5. If you know the ICN, enter it in the ICN# field. You can copy the ICN number from the service details of the record on the claims tab.

6. Click the blue **Search** command.
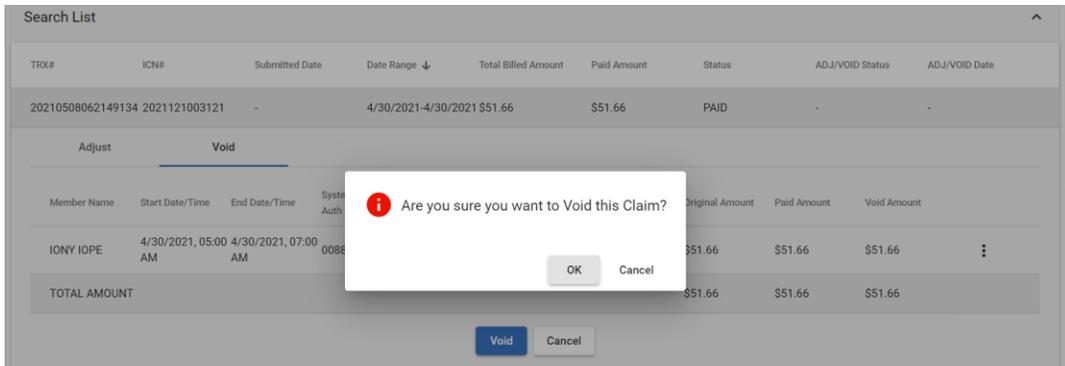

Warning: If the *claim contains multiple lines, all lines in the claim that have the same ICN, will be voided.*

7. Click anywhere on the record of the claim you want to void to view the details.

8. Click the blue **Void** command.

   Note: You click Cancel to exit the Void Claim window and return to the Voids and Adjustments Search List.

9. Click **OK** to void the claim.

Prior Authorization

You are here: Mobile Caregiver+ Claims Console > Prior Authorization

Topics covered in this chapter:

- Managing the Prior Authorization Search List

- Reviewing Prior Authorization Search List

- Manually Adding Prior Authorization to a Provider's Portal

- Editing Prior Authorizations

- Deleting Prior Authorizations

The Prior Authorization Menu option allows Providers to locate, review, and manage Prior Authorizations in their Mobile Caregiver+ Provider Portals. Depending on what the Payer and Program Recipients are enrolled in, some Providers may be able to manually add Prior Authorizations to, and/or edit existing Prior Authorizations in their Provider Portals.

Note: Providers should review the prior Authorization(s) that are loaded in their Mobile Caregiver+ Portals to ensure that none are missing. Provider should ensure that data listed in Prior Authorizations are correct, including, but not limited to, the Procedure Code (Service Code), the number of units authorized, the effective start date, the expiration date, the unit type, the limit type, the limit, etc. As an ongoing practice, Providers should review Prior Authorizations to increase the likelihood of receiving timely remittance.

Prior Authorizations that are loaded in a Provider's Mobile Caregiver+ Portal will have one of three statuses:

- **New**: A Prior Authorization that has a New status indicates that the Recipient has not received any service that has been billed/charged against the Authorization. The Units Used value for New Authorizations will be zero. New Authorizations have the full amount of units issued available to reimburse Providers for rendering service in the future.

- **Partially** Used: A Prior Authorization that has a Partially Used status indicates that the Recipient has received at least one or more services which has been billed against the Authorization. The Units Used value for Partially Used Authorizations will be greater than zero and less than the value of the Total Units Authorized. Partially

Used Authorizations still have remaining unit available that can be used to reimburse Providers for rendering service in the future.

- **Used**: A Prior Authorization that has a Used Status indicates that the Recipient has received the full amount of service that was authorized by the Payer. The Units Used value will be equal to the Number of Units Authorized value. Used Prior Authorization will have no (zero) units available to reimburse Providers for rendering service in the future.
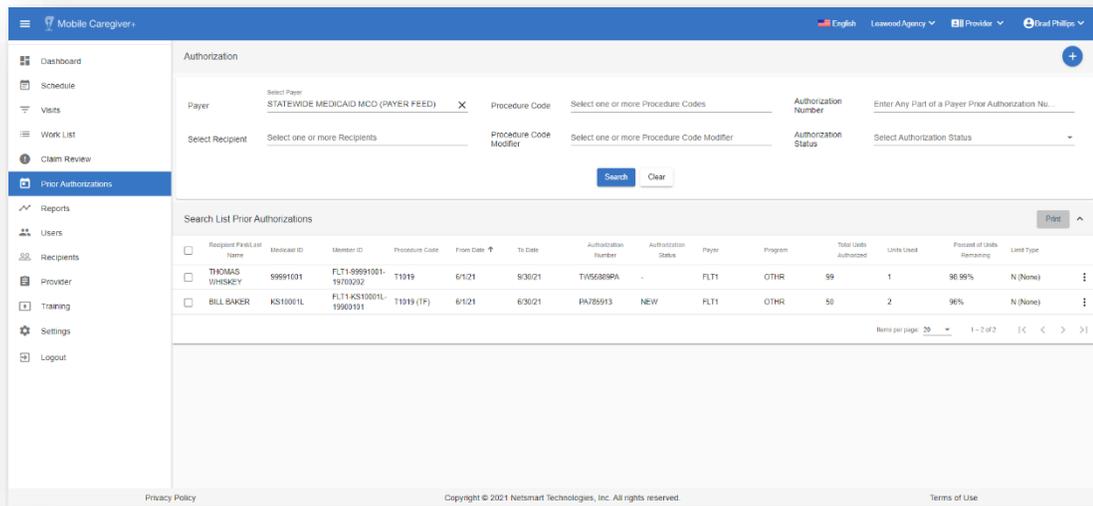
Managing the Prior Authorization Search List

You are here: Mobile Caregiver+ Claims Console > Prior Authorizations > Managing the Prior Authorization Search List

The Prior Authorization Menu option allows to Providers to locate, review, and manage Prior Authorizations in their Mobile Caregiver+ Provider Portals.

To access the Prior Authorization List:

1. From the Main Menu, click on **Prior Authorizations**.

2. Click in **Payer** field and select a Payer. Provider must select a Payer to proceed.

   Users can filter the list of Prior Authorizations by using the fields located in the header – Users can filter the Prior Authorization List by entering/selecting one or more search parameters in one or more of the following fields:

Field Name	Filter Description
Payer	Providers must select a Payer the system will display all Authorizations for all Recipients insured by the selected Payer. Providers should routinely check to ensure that all authorizations are loaded in their Provider Portals, for all the Recipients they provide service to. Providers must select a Payer.

Field Name	Filter Description
Procedure Code	Providers can filter the list of Authorizations by selecting one or more Service Codes. The system will only display Prior Authorizations for the selected Procedure Code(s).
Authorization Number	Providers can enter a unique Authorization Number to filter the list to display a specific Authorization.
Recipient	Providers can filter the list by selecting one or more Recipients – The system will only display Prior Authorizations for the selected Recipient(s).
Procedure Code Modifier	Providers can select one or more modifier(s) to add to selected Procedure Code(s). The system will further filter the list to only display Authorizations that contain both the combination of the selected Service Code(s), along with the selected Modifier(s).
Authorization Status	Providers can filter the list of Prior Authorizations by selecting one of the following Prior Authorization statuses: New, Partially Used, or Used.

3. Click the blue **Search** command to see a list of Prior Authorizations that match the search parameters.

4. Click on a Prior Authorization record to view the Prior Authorizaion details.

Reviewing Prior Authorization Search List

You are here: Mobile Caregiver+ Claims Console > Prior Authorizations > Managing the Prior Authorization Search List

The Prior Authorization Menu option allows Providers to locate and review Prior Authorizations in their Mobile Caregiver+ Provider Portals.

To Review the Prior Authorization Search List:

1. From the Main Menu, click **Prior Authorizations**.

2. Click in **Payer** field and select a Payer. Provider must select a Payer to proceed.

3. Enter any other optional search parameters. For this exercise we want to review all Prior Authorizations that are currently in our Provider Portal for all Recipients that are insured by the selected Payer.

4. Click the blue **Search** command.

Manually Adding Prior Authorizations to a Provider's Portal

You are here: Mobile Caregiver+ Claims Console > Prior Authorizations > Manually Adding Prior Authorizations to a Provider's Portal
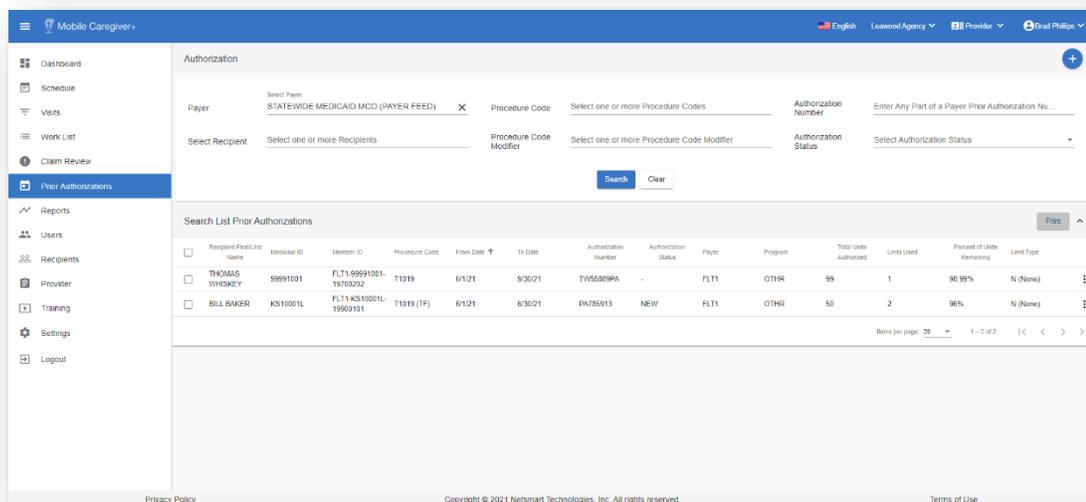
The Prior Authorization Menu option allows to Providers locate, review, and manage Prior Authorizations in their Mobile Caregiver+ Provider Portals.

Depending on the Payer and Programs Recipients are enrolled with, some Provider may be allowed to manually add and/or edit Prior Authorizations in their Provider Portals. Providers who can manually add Prior Authorizations to their portals will see the Add New Prior Authorization icon, ⊕, in the top right corner of the Prior Authorization screen.

Warning: All values being entered into the Add New Authorization form should be taken directly from an actual Authorization from the Payer – Please contact your Payer to obtain a copy of the actual Authorization.

To manually add a Prior Authorization to a Provider's Portal:

1. From the Main Menu, click on **Prior Authorizations**.

2. Click in **Payer** field and select a Payer. Provider must select a Payer in order to proceed.

3. Click the Add New Prior Authorization icon, ⊕, in the top right corner of the screen.

4. Enter the data for the Prior Authorization into the Add New form.

    i.   Click in the Payer field and select the Payer.

    ii.   Be sure the Program is set to "OTHR."

    iii.   Enter the Authorization Number.

    iv.   Enter the Start Date for the Authorization.

    v.   Enter the expiration date in the End Date field.

    vi.   Click in the Procedure Code field and select the Service Code.

    vii.   Click in the Modifier field and select any applicable Modifier(s).

    viii.   Enter the total number of units that are currently available in the Total Units Authorized field.

        Note: If any unit have already been deducted from the Authorization, please be sure to enter the actual number of units that are available at the time of adding the Authorization.

    ix.   Click in the Recipient ID field and select the Recipient.

    x.   Click in the Limit Type field and select the Limit Type.

    xi.   Enter the actual unit limits in the respective fields.

    xii.   Click in the Unit Type field and select the Unit Type.

5. Click the blue Save command to save the Authorization and close the Add New
    Form.

Editing Prior Authorizations

You are here: Mobile Caregiver+ Claims Console > Prior Authorizations > Prior Authorizations > Editing Prior Authorizations

The Prior Authorization Menu option allows Providers to locate, review, and manage Prior Authorizations in their Mobile Caregiver+ Provider Portals.

Depending on the Payer and Programs Recipients are enrolled with, some Providers may be allowed to manually add and/or edit Prior Authorizations in their Provider Portals.

To edit an existing Authorization in a Provider's Portal:

1. From the Main Menu, click on **Prior Authorizations**.

2. Click in **Payer** field and select a Payer. Provider must select a Payer to proceed.

3. Locate and click on the Actions icon for the Prior Authorization you want to edit.

4. From the shortcut submenu, click **Edit**.

5. Edit the data for the Prior Authorization.

    i. Be sure the Program is set to "OTHR."

    ii. Provider can edit the Authorization Number.

    iii. Provider can edit the Start Date for the Authorization.

    iv. Provider can edit the End Date field.

    v. Provider can edit the Procedure.

    vi. Provider can edit the Service Code Modifier(s).

    vii. Provider can edit Total Units Authorized field.

    viii. Provider can edit the Limit Type.

    ix. Provider can edit the actual unit limits in the respective fields.

    x. Provider can edit the Unit Type.

6. Click the blue Save command to save the changes and close the Add New Form.

Deleting a Prior Authorizations

You are here: Mobile Caregiver+ Claims Console > Prior Authorizations > Deleting a Prior Authorizations

The Prior Authorization Menu option allows Providers to locate, review, and manage Prior Authorizations in their Mobile Caregiver+ Provider Portals.

Depending on the Payer and Programs Recipients are enrolled with, some Providers may be allowed to delete Prior Authorizations in their Provider Portals.

To delete a Prior Authorization from your Provider's Portal:

1. From the Main Menu, click on **Prior Authorizations**.

2. Click in **Payer** field and select a Payer. Provider must select a Payer to proceed.

3. Locate and click on the Actions icon for the Prior Authorization you want to edit.

4. From the shortcut submenu, click **Delete**.
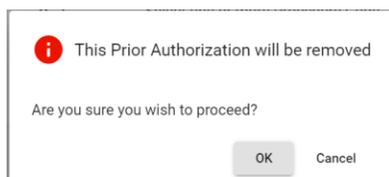
5. Click **OK** to delete the Prior Authorization and close the confirmation dialog box.

Reporting

Click a topic below:

[Generating a Report](#)

[Exporting a Report](#)

Generating a Report

You are here: [Mobile Caregiver+ Provider Portal User Guide](#) > [Reporting](#) > Generating a Report

The Provider Portal offers several reports, including the Time Log report that gives you a list of hours worked by a Caregiver, and the Visit Report that lets you see a list of completed tasks for Recipients (tasks are not shown in Visit Detail).

The Time Log report is used as an example in these instructions to show you how to generate a report. Filters are different for each report but making selections and generating all reports is the same.

To generate one of the standardized reports:

1. From the Main Menu, click **Reports**.

2. Click the name of the report you want to generate.

The system will generate a report based on the current days EVV activity.

3. Configure filter parameters – Use the fields located to the left of the sample report to configure custom filter parameter for your report.

- For some reports, like the Time Log Report shown, you may be able to enter a range, such as dates, for the data you want to see. Use the dropdown calendar for the **Start Date** and **End Date** to choose the date range you want to see payroll for.

- Filters like **Recipient** that have tabs titled **Available** and **Selected** allow you to select on or more Recipients for the report:

- Click *All* at the bottom of the list to add all data elements that appear on the **Available** tab.

- Click on individual elements on the **Available** tab to select and unselect elements what will be included in the report. The total number of selections will be displayed on the **Selected** tab.

- Remove all selected data elements by clicking *None* on the **Available** tab; the Selected tab will be updated accordingly.

4. Scroll down and click the blue **Apply** command to generate the report.

Use

Button	Description
Zoom in 🔍	Zoom in to enlarge report.
Zoom out 🔍	Zoom out to reduce size of report.
Page 2 of 36	See the number of the page displayed as well as the total number of pages in the report.
|<	Return to the first page of the report.
<	Move back one page.
>	Move forward one page.
>|	Move to last page of the report.

the

buttons listed below to view the contents of the report. Zoom options appear at the top of the page; paging options appear at the bottom of the page. You may need to scroll

down to see them. You can also export the report.
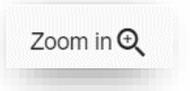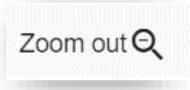
Button	Description
Zoom in 🔍	Zoom in to enlarge report.
Zoom out 🔍	Zoom out to reduce size of report.
Page 2 of 36	See the number of the page displayed as well as the total number of pages in the report.

Related Topic

- Exporting a Report

Exporting a Report

You are here: [Mobile Caregiver+ Provider Portal User Guide](#) > [Reporting](#) > Exporting a Report

To generate one of the standardized reports:

1. From the Main Menu click **Reports**.
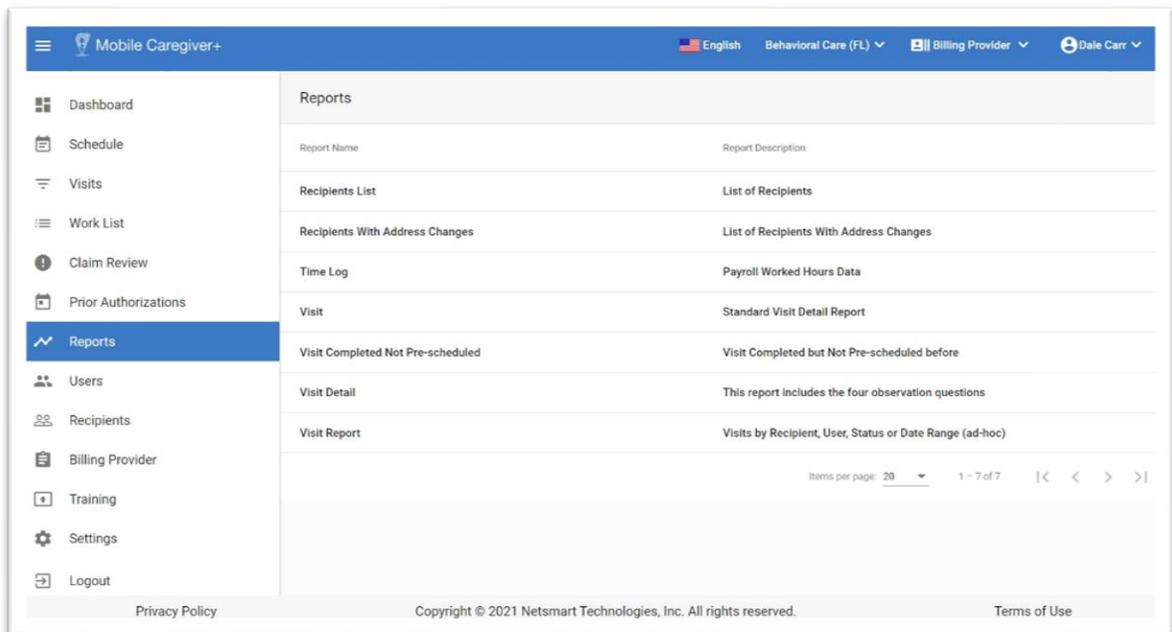
2. Click the name of the report you want to generate.

3. Use the filters to [select the data](#) you want included on your report and then click **Apply**.

4. Click the **Export** dropdown and select the format for your report.

When the report is downloaded, it will appear at the bottom left of your screen.

5. Click the download indicator to open the report.

Mobile Caregiver+ Provider Report List

Missed Visit Report

This report is available for Providers that have Mobile Caregiver+ Provider Portal subscriptions.

By default, the **Missed Visit Report** displays analytic data for visits that were cancelled for the current day.

The report will the display following data for each visit: Recipient Last Name, Recipient First Name, Recipient Medicaid ID, Recipient Member ID, Recipient DOB, Recipient Diagnosis Code, Payer, Service Code, Visit ID, Caregiver, Scheduled Start, Scheduled End, Missed Visit Reason Code, Missed Visit Reasons Notes, Missed Visit Action, Missed Visit Action Notes.

Providers can customize the default report using the controls on the left to select the following parameters:

- The Start Date and End Date for Missed visits.

- Caregiver(s).

- Recipient(s).

- Missed Visit Reason(s).

- Missed Visit Action(s).

MISSED VISITS REPORT
Date Range: March 1, 2022 - June 21, 2022
Report Date: 06/21/22

Record Count	Recipient Last Name	Recipient First Name	Recipient Medicaid ID	Recipient Member ID	Recipient DOB	Recipient Diagnoses	Payer	Service Code	Visit ID	Caregiver	Scheduled Start	Scheduled End	Missed Visit Reason	Missed Visit Reason Notes ▼	Missed Visit Action	Missed Visit Action Notes ▼
1	Alualu	Cadence	1111110005		03/31/1955		FLT1	S9122	0922505733	Dale Carr	05/10/2022 12:55:00 PM	05/10/2022 1:25:00 PM	OTHR	training	SCHD	training
2	Berry	Della	1111110006		10/07/1989		FLT1	S9122	2464288079	Dale Carr	04/12/2022 11:00:00 AM	04/12/2022 12:00:00 PM	MCAN	Recipient refused care	SCHS	schedul
3	Marie	Sophia	89971325	987654321	04/05/1996		FLT1	S9122	0155591313	Isabelle Khatri Schissler	04/03/2022 5:00:00 PM	04/03/2022 8:00:00 PM	MCAN	Recipient did not need services this day.	SCHD	Rescheduled for April 4 at same time.
4	Berry	Della	1111110006		10/07/1989		FLT1	S9122	2245873868	Dale Carr	05/26/2022 11:00:00 AM	05/26/2022 12:00:00 PM	OTHR	prov prt	OTHR	prov prt
5	Berry	Della	1111110006		10/07/1989		FLT1	S9122	2023361133	Dale Carr	05/12/2022 11:00:00 AM	05/12/2022 12:00:00 PM	OTHR	Provider Portal Training	OTHR	Provider Portal Training
6	Berry	Della	1111110006		10/07/1989		FLT1	S9122	3041927304	Dale Carr	04/28/2022 11:00:00 AM	04/28/2022 12:00:00 PM	MCAN	Provider Portal Training	OTHR	Provider Portal Training

Recipient List Report

This Report is available for Providers that have Mobile Caregiver+ Provider Portal subscriptions.

By default, the **Missed Visit Report** displays demographic data for all active Recipients.

The report will the display following data for each record: Recipient Name, Date of Birth, Gender, Recipient Address, Recipient Phone Number, Emergency Contact Name, Emergency Contact Phone.

Providers can customize the default report using the controls on the left to select the following parameters:

- Recipient(s).
- Gender.

Recipient List

Account Name	R.Count	Recipient Name	Date of birth	Gender	Recipient Address	Recipient Phone Number	Emergency Contact Name	Emergency Contact Phone
Sunshine Care of Florida								
	1	Anna Adeniyi	Oct 3, 1983	FEMALE				
	2	Anna Adeniyi	Oct 3, 1983	FEMALE	3651 FAU Boulevard Boca Raton FL 33431	(305) 745-4646	Adele Smith	3057845454
	3	Betsy Roethlisberger	Nov 15, 1951	FEMALE				
	4	Betsy Roethlisberger	Nov 15, 1951	FEMALE				
	5	Buck Rogers	Jul 4, 1945	MALE	800 Fairway Drive Deerfield Beach FL 33441	(555) 656-6789	Wilma Deering	15556566789
	6	Cadence Alualu	Mar 31, 1955	FEMALE				

Recipient With Address Change Report

This report is available for Providers that have Mobile Caregiver+ Provider Portal subscriptions.

By default, the **Recipient with Address Change Report** displays a list of Recipients whose Primary Address(es) were changed within the current date.

The report will the display following data for each Primary Address that has been changed: Primary Address, Change Date, Address, City, State, Zip.

Providers can customize the default report using the controls on the left to select the following parameters:

- The Start Date and End Date for Primary Address that were Changed.

Recipient With Address Change

Report Date: 6/21/2022

Report Date Range: 2/1/2022 - 6/21/2022

Primary Address	Change Date	Address	City	State	Zip
Anna Adeniyi					
Previous	03/03/2022	8998 Lewisburg Highway	Cornersville	TN	37047
Previous	02/17/2022	1598 Crestview Drive, Madison, TN, USA	Nashville	TN	37115
Previous	02/03/2022	2588 Loring Road Northwest	Kennesaw	GA	30152
Buck Rogers					
Previous	06/09/2022	887 Joe Stevens Road	Cedarbluff	MS	39741
Previous	05/26/2022	365 Court Street	West Point	MS	39773
Previous	05/19/2022	1313 Mockingbird Lane	The Villages	FL	32163
Cadence Alualu					
Previous	03/17/2022	0989 County Road 4	Wiggins	CO	80654
Elsa Monroe					
Previous	03/31/2022	788 West Marietta Street Northwest	Atlanta	GA	30318

Time Log Report

This feature is available for Providers that have Mobile Caregiver+ Provider Portal subscriptions.

By default, the **Time Log Report** displays time reported time log for visit completed in the current day by scheduled, actual and billable date and time.

The report will the display following data for each Completed visit: Caregiver, Employee ID, Recipient Name, Payer ID, Procedure Code, Scheduled Start, Scheduled End, Scheduled Hours, Actual Start Time, Actual End Time, Actual Hours, Billable Start Time, Billable End Time, Billable Hours, Billable-Actual Hours.

Providers can customize the default report using the controls on the left to select the following parameters:

- The Start Date and End Date for Completed visits.

- Recipient(s).

- Caregiver(s).

Caregiver	Employee ID	Recipient Name	Payer ID	Procedure Code	Scheduled Start	Scheduled End	Scheduled Hours	Actual Start Time	Actual End Time	Actual Hours	Billable Start Time	Billable End Time	Billable Hours	Billable-Actual Hours
Dale Carr		Buck Rogers	FLT1	S9122 TT	05/02/2022 4:00:00 AM	05/02/2022 7:00:00 AM	3.00	05/02/2022 4:00:00 PM	05/02/2022 4:05:00 PM	0.00	06/02/2022 4:00:00 PM	06/02/2022 7:00:00 PM	2.92	2.92
Dale Carr		Buck Rogers	FLT1	S9122 TT	05/20/2022 4:00:00 AM	05/20/2022 7:00:00 AM	3.00	05/20/2022 4:00:00 AM	05/20/2022 7:00:00 AM	3.00	06/20/2022 5:05:00 AM	06/20/2022 7:00:00 AM	1.92	-1.08
Dale Carr		Buck Rogers	FLT1	T1019	05/26/2022 4:00:00 AM	05/26/2022 7:00:00 AM	3.00	05/26/2022 4:00:00 AM	05/26/2022 7:00:00 AM	3.00	05/26/2022 4:00:00 AM	05/26/2022 7:00:00 AM	3.00	0.00
Dale Carr		Buck Rogers	FLT1	S9122 TT	05/06/2022 4:00:00 AM	05/06/2022 7:00:00 AM	3.00	05/06/2022 5:00:00 PM	05/06/2022 5:00:00 PM	0.00	05/06/2022 6:05:00 PM	06/06/2022 4:30:00 AM	2.50	2.50
Dale Carr		Buck Rogers	FLT1	T1019	05/24/2022 4:00:00 AM	05/24/2022 7:00:00 AM	3.00	05/24/2022 4:00:00 AM	05/24/2022 7:00:00 AM	3.00	05/24/2022 4:00:00 AM	05/24/2022 7:00:00 AM	3.00	0.00

Visit Report

The **Visit Report** displays visit details for Completed visits.

Provider must configure and select the following report parameters to filter and display the Visit Reports for specific a visit:

- The Start Date and End Date for the Completed visits.
- Recipient.
- Caregiver.

Reports > Visit

Export ∨   Zoom in 🔍   Zoom out 🔍

Start Date
2022-06-01

End Date
2022-06-21

Caregiver
Test User ▼

Recipient
Don Diego Vega ▼

[Apply] [Reset]

Run Date: 6/21/2022

Visit

Provider: Sunshine Care of Florida

Date Range: 6/1/2022   6/21/2022

Visit ID: 3118583346

Status	COMPLETED	**Actual Start Time:**	6/11/22 7:00:00 AM
Caregiver:	Test User	**Actual End Time:**	6/11/22 9:00:00 AM
Recipient:	Don Diego Vega	**Duration:**	02:00:00
HCPCS Code/Mod(s):	S9122		
Completed Tasks:	Laundry, Supervision		

Visit Service Report

This report is available for Providers that have Mobile Caregiver+ Provider Portal subscriptions.

By default, the **Visit Service Report** displays all scheduled visits for the current day.

The report will the display following data for each scheduled visit: Caregiver, Recipient Name, Service/HCPCS Code, Tasks, Recipient Address, Visit Start Date, Visit End Date, Actual Start Date, Actual End Date, Duration, Billable Start Time, Billable End Time, Status.

Providers can customize the default report using the controls on the left to select the following parameters:

- The Start Date and End Date for scheduled visits.

- Recipient(s).

- Caregiver(s).

- Status(es).

Visit-Services Report
SUNSHINE CARE OF FLORIDA
Date Range: June 1, 2022 - June 21, 2022

Caregiver	Recipient Name	Service/HCPCS Code	Tasks	Recipient Address	Visit Start Date	Visit End Date	Actual Start Date	Actual End Date	Duration	Billable Start Time	Billable End Time	Column1	Status
TEST USER	BUCK ROGERS	S9122	Medical Appointments, Shopping/Shopping	800 Fairway Drive Deerfield Beach FL 33441	Jun 3, 2022 2:00:00 AM	Jun 3, 2022 3:00:00 AM	Jun 3, 2022 2:00:00 AM	Jun 3, 2022 3:00:00 AM	01:00:00	Jun 3, 2022 2:00:00 AM	Jun 3, 2022 3:00:00 AM		Completed
DALE CARR	BUCK ROGERS	T1019	Housework/Chore, Grooming	365 Court Street West Point MS 39773	Jun 7, 2022 3:30:01 PM	Jun 7, 2022 4:30:01 PM	Jun 7, 2022 2:27:27 PM	Jun 7, 2022 2:29:27 PM	00:02:00	Jun 7, 2022 2:27:27 PM	Jun 7, 2022 2:29:27 PM		Completed
DALE CARR	BUCK ROGERS	S9122	Shopping/Shopping List, Medical Appointments,	365 Court Street West Point MS 39773	Jun 7, 2022 3:30:01 PM	Jun 7, 2022 4:30:01 PM	Jun 7, 2022 2:29:27 PM	Jun 7, 2022 2:30:31 PM	00:01:04	Jun 7, 2022 2:29:27 PM	Jun 7, 2022 2:30:31 PM		Completed
TEST USERTWO	BUCK ROGERS	S9122	Medical Appointments, Shopping/Shopping	800 Fairway Drive Deerfield Beach FL 33441	Jun 11, 2022 6:00:00 AM	Jun 11, 2022 8:00:00 AM	Jun 11, 2022 6:00:00 AM	Jun 11, 2022 8:00:00 AM	02:00:00	Jun 11, 2022 6:00:00 AM	Jun 11, 2022 8:00:00 AM		Completed
ISABELLA KHATRI SCHISSLER	BUCK ROGERS	S9122	Medical Appointments, Laundry,	800 Fairway Drive Deerfield Beach FL 33441	Jun 11, 2022 7:00:00 AM	Jun 11, 2022 9:00:00 AM	Jun 11, 2022 7:00:00 AM	Jun 11, 2022 9:00:00 AM	02:00:00	Jun 11, 2022 7:00:00 AM	Jun 11, 2022 9:00:00 AM		Completed
DALE CARR	BUCK ROGERS	S9122	Supervision, Personal Care - General	365 Court Street West Point MS 39773	Jun 8, 2022 11:15:01 PM	Jun 9, 2022 12:45:01 AM							In Progress, Late
TEST USER	BUCK ROGERS	S9122	Medical Appointments, Supervision,	800 Fairway Drive Deerfield Beach FL 33441	Jun 1, 2022 8:00:00 AM	Jun 1, 2022 10:00:00 AM							Missed
TEST USER	BUCK ROGERS	S9122	Medical Appointments, Shopping/Shopping	800 Fairway Drive Deerfield Beach FL 33441	Jun 1, 2022 8:00:00 AM	Jun 1, 2022 4:00:00 PM							Missed
TEST USER	BUCK ROGERS	S9122	Personal Care - General, Supervision,	365 Court Street West Point MS 39773	Jun 2, 2022 8:00:00 AM	Jun 2, 2022 10:00:00 AM							Missed