Billing

For Children’s Providers
Children and Family Treatment and Support Services and Aligned Children’s HCBS
Agenda/Objectives

I. Introduction
II. Revenue Cycle Management
III. Break
IV. Medicaid Provider Enrollment
V. Billing Manual Overview
VI. Questions
VII. Lunch – Medicaid Managed Care Plan Tabling
VIII. Children and Family Treatment and Support Services
IX. Submitting a Clean Claim
X. Questions
Introduction & Housekeeping

Housekeeping:

• Slides will be posted at MCTAC.org after the last of these events

Reminder: Information and timelines are current as of the date of the presentation
Revenue Cycle Management (RCM)
What is Revenue Cycle Management?

- All administrative and clinical functions that contribute to the capture, management, and collection of client service revenue.
- This describes the life cycle of a client account from creation to payment collection and resolution.
- The client account cycle is supported by a number of additional activities necessary to assure that all encounters are billable, meet regulatory requirements and revenue collection is maximized.
How is The Revenue Cycle Unique as an Organizational Process?

- Brings together workgroups and staff who do not work together in any other context
- Interdependencies exist across non-naturally occurring workgroups
- Revenue generation is the cornerstone of fiscal viability
- Inefficiencies, errors, and oversights can have a devastating impact
- Clinical priorities and fiscal/billing priorities are not always aligned
Process Flow Diagram:

1. Scheduling & Pre-registration
2. Point of service registration & collection
3. Charge Capture & Coding
4. Claim Submission
5. Payer follow-up
6. Remittance processing
7. Appeals, collections, and analysis

Central Node:
Contract Management
Quality Assurance
Utilization review
Credentialing
Regulatory Compliance
Phases of the Revenue Cycle

Prior to Service:
- Pre appointment activities
- Eligibility & Verification
- Scheduling

During Service:
- New Client Registration
- Eligibility & Verification
- Collection of Fees
- Charge Capture & Coding

Following Service:
- Claims Submission
- Payer follow-up
- Remittance Processing & Posting

On-going:
- Analysis
- Process Improvement
- Registration
Prior to Service

Eligibility verification

- When possible insurance eligibility and benefit verification should take place before the initial visit and checked regularly after that.

- Staff should have a working knowledge of the most commonly seen insurance plans and coverage options.
Prior to Service

Authorization

- Some plans may require authorizations that should be identified when verifying eligibility
- Each payer will have a unique process for securing authorizations
- Most authorizations will have timeframes and visit limits that will need to be tracked
Prior to Service

Scheduling

- When possible scheduling should be centralized and electronic
- If an insurance plan requires staff to have specific credentials to deliver a reimbursable service, care should be taken to ensure the client is scheduled with an approved provider in order to be reimbursed for the service.
During Service

New client registration

• Efficiently collect information necessary to establish a new client record including basic demographics, financial information, and financial agreements.

• Clients need to be made aware of fee policies and any payment responsibility they may have.

• Important to check eligibility
During Service

Eligibility Verification

- Medicaid Fee for service and Medicaid Managed care verifications can be done by:
  - Telephone
  - VeriFone Vx570
  - ePACES
  - Batch upload (270)

- The most efficient means to verify Medicaid eligibility is the electronic transmission of a 270 directly from the billing component of your EMR/EHR or billing software. A 271 will be returned to your billing system which should create a variance report for reconciliation.
During Service

Charge capture and coding

- Documenting the type and duration of service provided and transforming that into a data set necessary to support a clean claim.
  - Whenever possible charge capture should be standardized. One of the approaches is to develop and implement a Chargemaster.
  - EHR/EMR setup should make it easy to identify when a modifier should be applied to the base rate. The proper selection of modifiers is critical to revenue maximization because in many instances they are associated with higher reimbursement rates.
During Service

Charge Capture and Coding (continued)

• If the charge is not captured through the EHR/EMR then:
  ➢ Staff should be provided with a Chargemaster they can use to cross walk from the service they provided to the proper billing code.
  ➢ An efficient process must be in place to record, verify, and accurately report services provided to be entered into the billing program.
  ➢ Care must be taken to assure that minimum duration standards are met and that the CPT code for the transaction matches the start and end time on the clinical documentation.
Improper or Inaccurate Coding

- Improper or inaccurate coding carries a significant risk of disallowance upon subsequent audit
  - Strong quality assurance programs must be in place to assure codes are correct and supported by the clinical documentation.
  - It is essential that staff understand the billing rules that guide their practice and documentation.
After Services

Claim submission

► Submission of billable fees to the insurance company via the required universal claim form.
  o Claim data can be submitted directly to the payer or through a clearinghouse
  o Processes must be in place to “scrub” claims to assure that they are clean.
After Services

Claim submission

- Some common tests should be:
  - Was the claim formatted correctly and are all required data elements present
  - Was the service of the required duration for the code
  - Was the documentation completed properly:
    - Progress note was completed
    - Service was on the treatment plan
    - Treatment plan was up to date
- Claims should be submitted as soon as feasible
After Services

Improper Claiming

Improper claiming can be very costly

- Each claim that is rejected due to improper formatting must be “touched” and resubmitted
- Claims that are submitted without adherence to documentation regulations create a huge risk for disallowance upon audit
After Services

Capturing Errors

- EMR/EHR can suspend claims and alert staff to errors that renders the claim unbillable and support quality improvement efforts and regulatory compliance.

- If there is no EMR scrubbing of claims it is essential that there is an active Quality Assurance process that identifies improper claims and voids them when necessary.

- Clearinghouses can do a good job at scrubbing claims with technical errors but only an EMR/EHR with a billing component can evaluate claims for compliance with documentation requirements.
After Services

Denials

- Review denials on a regular basis
- Review each denied claim and determine the cause
- Adjudicate claims, correct errors and resubmit promptly
- Identify preventable denials and apply a quality improvement process to correct the issue
After Services

Examples of Common Denials

- Claim was submitted after the allowable time period
- Visit was not authorized
- Client was not eligible
- Provider was not credentialed
- Claim had incorrect client or provider data
- Provider technical error
- Payer technical error
After Services

Not Just Denials:

- **Not Billed**
  - Due to EHR/EMR billing rules, claims might be held back. These are not denials
  - Clearinghouse can also hold claims back due to their rules

- **Rejection**
  - Due to numerous errors, claims might not be processed (never get to the payer) at all and fall into rejection category, for example, wrong ID or Name on the claim.

- **Pending**
  - Sometimes the payer, including Medicaid, will Pend the claim due to missing information or further reviews internally
After Services

Remittance Process and Posting

- Posting and applying payments and adjustments to client accounts and posting payments in aggregate amounts to the General Ledger
  - Post payments in a timely fashion
  - Compare payments received to amounts billed and reconcile differences
  - Review adjustments made by the payer to individual claim. Appeal adjustments when warranted
Ongoing Analysis

- Review and evaluate the effectiveness of your revenue cycle management and the performance of your payers.
  - Create an analysis standard metrics to identify issues and processes that may need improvement
  - Quantify issues related to payers and discuss with your customer service representatives
Some standard metrics

- **Collection ratio**: a total collected to total billed reviewed by payer and payer class.

- **Aged accounts receivable**: Dollar value of accounts receivables tracked by amount of time they have been outstanding:
  - Less than 30 days
  - 30 – 60 days
  - 60 – 90 days
  - 90 – 120 days
Ongoing

- Standard metrics continued
  - Denial report – percentage and amount of claims denied by reason, clinician, and payer
  - Percentage of claims paid upon initial submission

Process improvement

- Formalized process using your analytics to identify problems, create solutions, implement change, and measure the results.
How Might You Address the Operational Challenges?

- Clearly articulate measurable performance standards for all staff with involvement in the revenue cycle process

- Measure against these standards regularly and differentiate people problems from system problems

- Address people problems quickly and effectively
How Might You Address the Operational Challenges?

- Provide staff with the tools and information they need to successfully carry out their tasks
- Implement a quality improvement process & team to address system problems and:
  - Bring together workgroups and staff
  - Create Tools
  - Decide upon and Measure against standards
  - Document
  - Address Problems Quickly
  - Communication
- Assure that Executive, Clinical, and Finance leadership are on the same page and speak with a single voice regarding revenue and the critical role it plays in supporting the mission of the organization

mctac
Tools to Support Revenue Cycle Management

A full featured properly implemented EHR/EMR with a strong billing component can bring significant efficiencies and accuracy to the revenue cycle process:

- Provide electronic scheduling to maximize the use of provider capacity
- Efficiently evaluate insurance eligibility
- Track authorizations and alert staff when they are approaching thresholds
- Behind the scenes management of charge capture and coding to eliminate errors, maximize revenue and minimize audit risk
Tools to Support Revenue Cycle Management

• Catch and suspend claims that do not meet payer and documentation requirements minimizing audit risk
• Efficiently post payments to maintain accurate client accounts
• Provide reports necessary to address staff, system, and payer performance issues
Some Options

Short of a fully functional EMR/EHR, for a strong Revenue Cycle Management system, here are some essentials:

• Outsourcing billing services
• Clearing House Services
• In house stand alone billing systems are available
• A combination of in house billing systems (either EMR/EHR or stand alone based) and a clearinghouse claims processer is also an option.
MCO Tips for successful RCM

- Develop a good relationship with your clearinghouse vendor
- Review HIPAA requirements for electronic claim submissions
- Review and respond to clearinghouse reports (i.e. acceptance and denials)
- Promptly make corrections and submit the claim(s) to clearinghouse
- Review and respond to payer provider remittance advices to allow time to make corrections and appeals
MCO Tips for successful RCM

- Remember **timely filing** deadlines
- Review and update your 837i or UB-04 claim form and make adjustments to ensure correct information is in each field to avoid delay/denial of payment with managed care payers
- Be mindful that claims forms often have pre-populated fields which worked for FFS but won’t work with MCO’s
- Sign up for Electronic Payments and Statements with each payer
- Know about the unlicensed practitioner number for OMH and OASAS
Remember

CLAIMS TESTING
CLAIMS TESTING
CLAIMS TESTING
Break
Medicaid Provider Enrollment
Medicaid Provider Enrollment

To bill and be reimbursed by Medicaid for services provided:

• Provider Agencies need to be enrolled in Medicaid.
• Provider agencies and individual staff providing new state plan services and Aligned Home & Community Based Services (HCBS) need to have an National Provider Identifier (NPI) number to ensure proper reimbursement.
• Provider Agencies enrolled as a Medicaid provider need to have their NPI associated with their Medicaid Provider number.
Obtaining an NPI

» Choose the appropriate taxonomy code to be entered in the NPI application.

» All Agency Provider and Individual Staff (licensed/non-licensed) must apply for a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES).

» An Agency Provider must select the Healthcare Provider Taxonomy Code which is a description the provider determines most closely describes the provider's type/classification/specialization.

» Individual Staff: Select the taxonomy code for a licensed individual if you are licensed or for a non-licensed individual if you are not.
The 21st Century Cures Act (Act) requires all Medicaid Managed Care (MMC) and Children’s Health Insurance Program providers to enroll with state Medicaid programs by January 1, 2018.

MCO Provider Enrollment Outreach Letter
- MCO only required to send notice to providers not enrolled and able to enroll.
- Some MCOs sent Outreach Letter to all network providers, including:
  - providers who are already Medicaid enrolled; and
  - providers who cannot enroll in Medicaid.
### Examples of Medicaid Enrollment Requirements for BH provider types

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Enrollment Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Mental Health Counselor</td>
<td>Not required to enroll</td>
</tr>
<tr>
<td>Licensed Marriage Family Therapist</td>
<td>Not required to enroll</td>
</tr>
<tr>
<td>CSW (Clinical Social Worker)</td>
<td>Required to enroll (required to enroll in Medicare prior to Medicaid)</td>
</tr>
<tr>
<td>Applied Behavioral Analyst</td>
<td>Not required to enroll</td>
</tr>
<tr>
<td>Adult Home And Community Based Services OMH</td>
<td>Not required to enroll</td>
</tr>
<tr>
<td>Children’s Home And Community Based Services OMH</td>
<td>Required to enroll</td>
</tr>
<tr>
<td>LMSW (Licensed Master Social Worker)</td>
<td>Not required to enroll</td>
</tr>
<tr>
<td><strong>OMH Licensed ACT Provider</strong></td>
<td>Required to Enroll</td>
</tr>
<tr>
<td><strong>OMH Licensed PROS Provider</strong></td>
<td>Required to Enroll</td>
</tr>
<tr>
<td><strong>OMH Licensed Outpatient Provider</strong></td>
<td>Required to Enroll</td>
</tr>
</tbody>
</table>

A comprehensive list of provider types who can currently enroll in Medicaid (NYS Enrollable Providers) is located at: https://www.emedny.org/info/ProviderEnrollment/ManagedCareNetwork/index.aspx
How to identify if a provider is already enrolled as a Medicaid FFS provider

- Practitioners can verify if they are enrolled by using the enrolled practitioners search function found on https://www.emedny.org/info/opra.aspx

- Business, Group Practice and Institutional providers can verify their enrollment by calling eMedNY Call Center at (800) 343-9000
Medicaid Provider Enrollment Resources

- FFS Medicaid Enrollment for OMH Behavioral Health Providers in Medicaid Managed Care Networks FAQ
- OMH Medicaid Provider Enrollment Webinar
- Medicaid Provider Enrollment for New Children’s Services Providers
Billing Manual Overview
Billing Manual

Overview

- The information contained in the billing manual, subject to required State and Federal approvals, reflects the billing structures for the Children’s System Transformation scheduled to begin on January 1, 2019.
- TBD Billing criteria will be updated by the State. Future updates will only supplement current information, not change what is already in place.
- Please use the manual to begin preparation of your claiming systems.
Transitional Period

A supplemental billing manual, **New York State Children’s Health and Behavioral Health (BH) Services – Children’s Medicaid System Transformation Guidance for the Transitional Period**, includes guidance on transitional billing procedures, including transitional billing procedures for waiver providers that will transition to Health Home rates and for HCBS services that will transition to State Plan services after January 1, 2019.
BH State Services Transition to MMCP

- New York State Plan BH services available to children under age 21 will be transitioned into Medicaid Managed Care on July 1, 2019:
  - Assertive Community Treatment (ACT) (minimum age is 18 for medical necessity for this adult oriented service)
  - Comprehensive Psychiatric Emergency Program (CPEP) (including Extended Observation Bed)
  - Continuing Day Treatment (CDT) (minimum age is 18 for medical necessity for this adult oriented service)
  - OMH SED designated clinics, which were previously carved out of MMC for children with SED diagnoses.
BH State Services Transition to MMCP Continue

• Services Continued:
  • Personalized Recovery Oriented Services (PROS) (minimum age is 18 for medical necessity for this adult oriented service)
  • Partial Hospitalization
  • OASAS Outpatient and Opioid Treatment Program (OTP) services
  • OASAS Outpatient Rehabilitation services
  • OASAS Outpatient Services • Residential Addiction Services
Fundamental Requirements

- Providers must be designated to provide and be reimbursed for new Children and Family Treatment and Support Services and Aligned Children’s HCBS.

- All designated providers are required to enroll as a Medicaid Provider in order to be paid for delivering a Medicaid service.

- For Medicaid Managed Care Plan, a provider must be contracted and credentialed with that MMCP for the service rendered (i.e. in the MMCP’s network).

mctac
VFCA and Billing

- VFCAs who are designated to provide Children and Family Treatment and Support Services and Home and Community Based Services will need to contract, claims test and establish revenue cycle management practices for the provision of the services they will provide.

- VFCAs will be able to apply what they have learned regarding contracting, claims testing and revenue cycle management after they receive their 29I licensure and are able to bill for the residual per diem starting July 1, 2019

- A separate 29I residual per diem Billing manual will be issued

- A set of new rate codes for the residual per diem will also be issued
Medicaid Managed Care Plan (MMCP)

NETWORK AND CLAIMING REQUIREMENTS
MMCP Network Requirements

- Medicaid Managed Care Plans are held to specific network requirements. NYS monitors MMCP contracting regularly to ensure network requirements are met.
- A Medicaid Managed Care Plan has discretion to deny a claim from an out of network provider.
- **Exception** for newly carved in services, if a provider is delivering a service to the enrollee prior to the implementation date.
MMCP Network Requirements

MMCP must allow a provider to continue to treat an enrollee on an out of network basis for up to 24 months following the implementation date by providing a single case agreement.
Single Case Agreement

• Single Case Agreements (SCA) may be executed between a MMCP and a provider when an out of network provider has been approved by a MMCP to deliver specific services to a specific MMCP enrollee.

• Medicaid Managed Care Plans must execute SCAs with non-participating providers to meet clinical needs of children when in-network services are not available.
Claim Submission

- MMCPs and providers must adhere to the rules in this billing and coding manual.
- MMCP shall support both paper and electronic submission of claims.
- MMCP shall offer its providers an electronic payment option including a web-based claim submission system.
Billing Requirements

- Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in “24” followed immediately with the appropriate four-digit rate code.

- Every claim submitted will require at least:
  - 837i (electronic) or UB-04 (paper) claim format;
  - Rate code;
  - Valid CPT code(s);
  - CPT code modifiers (as needed); and
  - Units of service
Staff Transportation

- There will NOT be a separate rate code for staff transportation
- Staff transportation costs have been built in to the offsite rates
Service Combinations
# NYS Allowable Billing Combinations of Children’s Behavioral Health, Children and Family Treatment and Support Services and HCBS

<table>
<thead>
<tr>
<th>HCBS/State Plan Services</th>
<th>OMH Clinic</th>
<th>OASAS Clinic</th>
<th>OASAS Opioid Treatment Program</th>
<th>OMH ACT</th>
<th>OMH PROS*</th>
<th>OMH CDT*</th>
<th>OMH Partial Hospital</th>
<th>OASAS Outpatient Rehab</th>
<th>CPST / OLP</th>
<th>PSR</th>
<th>FPSS</th>
<th>YPST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Habilitation</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Caregiver &amp; Family Support and Services</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Respite</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Prevocational Services</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>HCBS/State Plan Services</td>
<td>OMH Clinic</td>
<td>OASAS Clinic</td>
<td>OASAS Opioid Treatment Program</td>
<td>OMH ACT</td>
<td>OMH PROS*</td>
<td>OMH CDT*</td>
<td>OMH Partial Hospital</td>
<td>OASAS Outpatient Rehab</td>
<td>CPST/OLP</td>
<td>PSR</td>
<td>FPSS</td>
<td>YPS</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>------------</td>
<td>--------------</td>
<td>--------------------------------</td>
<td>---------</td>
<td>-----------</td>
<td>----------</td>
<td>--------------------</td>
<td>-----------------------</td>
<td>----------</td>
<td>-----</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Community Self-Advocacy Training and Supports</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Licensed Practitioner (OLP)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Community Psychiatric Supports and Treatment (CPST)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>-</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>-</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>HCBS/State Plan Services</td>
<td>OMH Clinic</td>
<td>OASAS Clinic</td>
<td>OASAS Opioid Treatment Program</td>
<td>OMH ACT</td>
<td>OMH PROS*</td>
<td>OMH CDT*</td>
<td>OMH Partial Hospital</td>
<td>OASAS Outpatient Rehab</td>
<td>CPST/OLP</td>
<td>PSR</td>
<td>FPSS</td>
<td>YPST</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------</td>
<td>--------------</td>
<td>-------------------------------</td>
<td>---------</td>
<td>-----------</td>
<td>---------</td>
<td>---------------------</td>
<td>------------------------</td>
<td>----------</td>
<td>-----</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td><strong>Youth Peer Support and Training</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Family Peer Support</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Crisis Intervention</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Palliative Care</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Accessibility Modifications</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Adaptive and Assistive Equipment</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Questions?
Lunch and Tabling
Children and Family Treatment and Support Services
Key Points

- Each service has a distinct rate code
- Each claim must include the appropriate CPT code as noted in the rate table
- Claims are billed daily.
Off-Site Services

- All services may be provided on-site or off-site (Off-site delivered in a community based location other than the agency’s designated address)
- Off-site services would be billed with one claim for the service rate code and a second claim for the off-site rate code. Both claims would have the same procedure code.
## Onsite and Offsite billing

<table>
<thead>
<tr>
<th></th>
<th>Individual receiving service</th>
<th>Group receiving service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onsite</strong></td>
<td>• Submit one claim for base service cost</td>
<td>• Submit one claim for each group member for base service cost</td>
</tr>
<tr>
<td><strong>Offsite</strong></td>
<td>• Submit first claim for base service cost</td>
<td>• Submit first claim for each group member for base service cost</td>
</tr>
<tr>
<td></td>
<td>• Submit second claim for offsite consideration</td>
<td>• Submit second claim for each group member offsite consideration</td>
</tr>
</tbody>
</table>
Other Licensed Practitioner (OLP)
The following practitioners may provide and be reimbursed for OLP services:

- Licensed Psychoanalyst
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Mental Health Counselor
- Licensed Master Social Worker under the supervision or direction of a Licensed Clinical Social Worker, Licensed Psychologist or a Psychiatrist.
Claims for OLP initial evaluation are defined using distinct rate codes. Off-site services would be billed with one claim for the service rate code and a second claim for the off-site rate code. These would both have the same procedure code.

Claims are billed daily.

Assessments may be provided on-site or off-site (Off-site delivered in a community based location other than the agency’s designated address)

Each claim must include the appropriate CPT code as noted in the rate table
Individual counseling services are defined using distinct rate codes based on whether the service was provided to an individual or the family (with or without the individual present or attending) and whether the service was provided on-site or off-site.

Family counseling claims must also include the appropriate modifier in addition to CPT code.

Claims are billed daily, in 15 minute units,

Daily Limit of four units (1 hour).
Group sessions are billed daily, with a separate claim for each member in the group, in 15 minute units,

- Daily unit limit of four units (1 hour) per individual.
- Group size may not exceed more than eight members.
- Group sessions may be provided on-site or off-site.
OLP Crisis

- The OLP crisis services are NOT part of the separate Crisis Intervention State Plan services.
- Any consumer receiving this service must have already been evaluated and under the care of the practitioner delivering the OLP (counseling, and evaluated) prior to using the crisis components.
- The reimbursement categories - Crisis Triage (By telephone), Crisis Off-Site (In-person) and Crisis Complex Care (Follow up) allow the NB-LBHP to provide the necessary interventions in crisis circumstances.
OLP: Crisis

▶ Off-Site
• Claims are billed daily, in 15 minute units, with a daily unit limit of eight units (two-hour daily maximum).
• May only be provided off-site.
• Only one claim is submitted for OLP Crisis. Reimbursement already reflects off-site component.

▶ Triage
• Claims are billed daily, in 15 minute units, with a daily unit limit of two units (30-minute daily maximum).

▶ Crisis Complex Care (follow-up to Crisis)
• Claims are billed daily, in five minute units, with a daily unit limit of four units (20-minute daily maximum).
• Provided by telephone.
Community Psychiatric Support and Treatment (CPST)

Claims for CPST services are defined based on individual/family or group and where the service is provided (i.e., on-site/non-travel off-site or off-site). See Appendix A of Billing Manual for the list of rate codes and descriptions.
CPST – Service Professional – Individual/Family

- Billed daily, in 15 minute units.
- Daily limit of six units per day (1.5 hours).
- May be provided on-site or off-site.
- Off-site daily with a limit of 1 unit per day.
CPST – Group

- Group services are billed daily, in 15 minute units,
- Daily limit of four units per day (1 hour).
- Group size may not exceed more than eight members.
- CPST group sessions may be provided on-site or off-site.
Psychosocial Rehabilitation (PSR)

▸ PSR is divided into two different types of sessions: Individual and Group.

▸ Claims for PSR services are defined using distinct rate codes based on the type of service provided (i.e., individual or group)
PSR – Service Professional - Individual

- Individual services are billed daily in 15 minute units
- Daily limit of eight units per day (2 hour daily maximums).
- May be provided on-site or off-site.
- Off-site billed daily with a limit of 1 unit.
PSR – Service Professional - Group

- Group services are billed daily, in 15 minute units.
- Daily limit of four units per day (1 hour).
- Group size may not exceed more than eight members.
- PSR Group sessions may be provided on-site or off-site.
- Off-site PSR billed daily, with a limit of 1 unit, per client, per day.
<table>
<thead>
<tr>
<th>New Service</th>
<th>Practitioners</th>
<th>Modality</th>
<th>Setting</th>
<th>Staff Trans.</th>
<th>Billing Intervals</th>
<th>Daily Limit</th>
<th>Group Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>OLP</td>
<td>Licensed Psychoanalyst, LCSW, LMFT, LMHC, LMSW (under supervision)</td>
<td>Individual/Group/Family</td>
<td>Off Site/On Site</td>
<td>Allowed. Separate claim must be submitted for staff trans.</td>
<td>Evaluation: Daily Counseling and Crisis: 15 Min Unit except Crisis Complex Care: 5 Min</td>
<td>Counseling: 4 Units Crisis Off-site: 8 Units, Crisis Triage: 2 Units, Crisis Complex Care: 4 Units</td>
<td>8 Members per group max</td>
</tr>
<tr>
<td>CPST</td>
<td>Varies by component service</td>
<td>Individual/Group/Family</td>
<td>Off Site/On Site</td>
<td>Allowed. Separate claim must be submitted for staff trans.</td>
<td>15 Minute Unit, Off-site billed Daily</td>
<td>Individual/Family: 6 Units (1.5 Hours) Group: 4 Units (1 hour) Offsite: 1 unit</td>
<td>8 Members per group max</td>
</tr>
<tr>
<td>New Service</td>
<td>Practitioners</td>
<td>Modality</td>
<td>Setting</td>
<td>Staff Transportation</td>
<td>Billing Intervals</td>
<td>Daily Limit</td>
<td>Group Size</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------</td>
<td>----------</td>
<td>---------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>PSR</td>
<td>18 years old High School Diploma, equivalency, SACC or CDOS 3 yrs. Experience in children’s MH, SUD &amp;/or Foster Care</td>
<td>Individual /Group</td>
<td>Off Site/On Site</td>
<td>Allowed. Separate claim must be submitted for staff transportation</td>
<td>15 Minute Unit, Off-site billed Daily</td>
<td>Individual: 8 Units (2 Hours) Group: 4 Units (1 hour) Offsite: 1 unit</td>
<td>8 Members per group max</td>
</tr>
</tbody>
</table>
Clean Claims
Important

Please note this guidance applies to outpatient/ambulatory services only.
Overview

- All Electronic claims will be submitted using the 837i (institutional) claim form
- UB-04 should be utilized when submitting paper claims
- Insurance Law § 3224-a requires insurers and health maintenance organizations to pay undisputed claims within 45 days after the insurer receives the claim, or within 30 days if the claim is transmitted electronically.
Credentialing

- When credentialing MCO shall accept state licenses/designation, operation and certifications in place of, and not in addition to, any MCO credentialing process for individual employees, subcontractors or agents of such providers.
- MCOS can still collect and accept program integrity related information from providers.
- MCOs shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.
Tips for Clean Claims Submission

- Claims are submitted using standard, CMS defined/approved templates.
- Most businesses find it most economical and efficient to bill electronically. Electronic claims are submitted using an 837.
- 837s are standardized so that they can feed data directly into a database in a 1:1 transfer.
- It is very important that you enter appropriate data in each field.
  - For example, just as you would not enter a procedure code in the surname field on a paper claim, you should also make sure that the same happens in electronic format.
You have the option to procure/build your own claiming software or contract with a billing vendor.

- Procurement will require upfront funds.
- Billing vendors typically charge a percentage of total revenue or a flat rate per claim.

You typically receive payment more quickly when billing electronically using 837, because the claim can usually be reviewed by a system instead of a person.
Tips for Clean Claims Submission con’t

► If you choose to submit paper claims, the claim needs to be reviewed by a person, which typically takes longer, and if the claim is not “clean” (if there are errors or missing information) it will need to be returned to you via mail, corrected by hand, and resubmitted manually before payment can be made.

► Although paper and electronic claim forms are standardized, certain fields might vary from plan to plan. For example, one plan might require an piece of information that is optional at another plan. Or, the specific definition of a field might vary from plan to plan.
FL 01

Billing Provider Information

- Billing Provider Name
- Billing Street Address
- Billing Provider City, State, Zip
- Billing Provider Telephone, Fax, Country Code

REQUIRED
Billing Provider’s Designated Pay-to Name
Billing Provider’s Designated Pay-to Address
Billing Provider’s Designated Pay-to City State
Billing Provider’s Designated Pay-to ID

NOT REQUIRED with the exception of:

- Wellcare
- United Healthcare
- Emblem Health/Beacon
- Excellus: required when “pay to” entity is different than information in box 1
a) Patient Control Number (member unique alpha-number control number assigned by provider)

REQUIRED with exception of United/Optum, Wellcare, Excellus and Beacon

b) Medical/Health Record Number

NOT REQUIRED
Type of Bill – 4 Digit Alphanumeric Code.

- **1st Digit** – 0 (leading 0)
- **2nd Digit** – Identifies the type of facility
- **3rd Digit** – Identifies type of care
- **4th Digit** – The sequence of this bill, referred to as “Frequency.

**REQUIRED**

See Following Slide for Code Set
Type of Bill – Codes

- **1st Digit** – 0 (leading 0)
- **2nd Digit** – Identifies the type of facility

1. Hospital
2. Skilled Nursing
3. Home Health Facility (Includes Home Health PPS claims, for which CMS determines whether the services are paid from the Part A Trust Fund or the Part B Trust Fund.)
4. Religious Nonmedical (Hospital)
5. Reserved
6. Intermediate Care (not used for Medicare)
7. Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8. Special facility or hospital ASC surgery (requires special information in second digit below).
9. Reserved

See Following Slides for 3rd and 4th Digit Code Set
3rd Digit-Bill Classification (Except Clinics and Special Facilities)

1. Inpatient (Part A)
2. Inpatient (Part B) - (For HHA non PPS claims, Includes HHA visits under a Part B plan of
3. Outpatient (For non-PPS HHAs, includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment). For home health agencies paid under PPS, CMS determines from which Trust Fund, Part A or Part B. Therefore, there is no need to indicate Part A or Part B on the bill.
4. Other (Part B) - Includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for “nonpatients,” and referenced diagnostic services. For HHAs under PPS, indicates an osteoporosis claim. NOTE: 24X is discontinued effective 10/1/05.
5. Intermediate Care - Level I
6. Intermediate Care - Level II
7. Reserved for national assignment (discontinued effective 10/1/05).
8. Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).
9. Reserved for National Assignment
3rd Digit-Classification *(Clinics Only when 7 is used as a second digit)*

1. Rural Health Clinic (RHC)
2. Hospital Based or Independent Renal Dialysis Facility
3. Free Standing Provider-Based Federally Qualified Health Center (FQHC)
4. Other Rehabilitation Facility (ORF)
5. Comprehensive Outpatient Rehabilitation Facility (CORF)
6. Community Mental Health Center (CMHC)
7. Reserved for National Assignment
8. Reserved for National Assignment
9. OTHER
### FL 04 Cont.

<table>
<thead>
<tr>
<th>3rd Digit (Special Facility Only)</th>
<th>4th Digit-Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospice (Nonhospital Based)</td>
<td>1. Admit Through Discharge Claim</td>
</tr>
<tr>
<td>2. Hospice (Hospital Based)</td>
<td>2. Interim-First Claim</td>
</tr>
<tr>
<td>3. Ambulatory Surgical Center</td>
<td>3. Interim-Continuing Claims</td>
</tr>
<tr>
<td>Services to Hospital Outpatients</td>
<td>4. Interim-Last Claim</td>
</tr>
<tr>
<td>4. Free Standing Birthing Center</td>
<td>5. Late Charge Only</td>
</tr>
<tr>
<td>5. Critical Access Hospital</td>
<td>7. Replacement of Prior Claim</td>
</tr>
<tr>
<td>6. Reserved for National Assignment</td>
<td></td>
</tr>
<tr>
<td>7. Reserved for National Assignment</td>
<td></td>
</tr>
<tr>
<td>8. Reserved for National Assignment</td>
<td></td>
</tr>
<tr>
<td>9. OTHER</td>
<td>8. Void/Cancel of a Prior Claim</td>
</tr>
<tr>
<td></td>
<td>9. Final Claim for a Home Health PPS Episode</td>
</tr>
</tbody>
</table>
Federal Tax ID Number

Providers should **not** use a hyphen in the tax ID field

REQUIRED
Statement Covers Period – From/Through

- OMH Billing: When billing for monthly rates, only one date of service is listed per claim form. Enter the date in the FROM box. The THROUGH box may contain the same date or may be left blank.
- OASAS OTP: Please refer to updated Billing Manual for further guidance.
- Dates must be entered in the format MMDD YYYY

REQUIRED:
Please note for Excellus: THROUGH box cannot be left blank, if service was performed on one date the THROUGH box should contain the same as the FROM box.
FL 08

a) Patient Name

b) Patient Name

REQUIRED
a) Patient Address- Street
   REQUIRED, except Emblem Health/Beacon
b) Patient Address- City
   NOT required, except Excellus and United Healthcare
c) Patient Address- State
   NOT required, except Excellus and United Healthcare
d) Patient Address- ZIP
   NOT required, except Excellus and United Healthcare
e) Patient Address- Country Code
   NOT required, except Excellus
Patient Birthdate

- The birth date must be in the format MMDDYYYY

REQUIRED
FL 11

Patient Sex

REQUIRED
FL 12

Admission Date/Start of Care Date

NOT REQUIRED, except Emblem Health/Beacon where can be situationally required and Excellus where is required
FL 13

Admission Hour

NOT REQUIRED, except Emblem Health/Beacon where can be situationally required
FL 14

Priority (Type) of Admission or Visit

NOT REQUIRED, with exception of Emblem Health/Beacon and Excellus
FL 15

Point of Origin for Admission or Visit (SRC)

NOT REQUIRED, except for Empire Blue Cross Blue Shield HealthPlus for UB, Excellus, BlueCross BlueShield of WNY and Fidelis. Emblem Health/Beacon requires situationally.
FL 16

Discharge Hour

NOT REQUIRED, with the exception of Emblem Health/Beacon where can be situationally required
Patient Discharge Status

NOT REQUIRED with the exception of WellCare, Empire Blue Cross Blue Shield HealthPlus, Emblem Health/Beacon, Fidelis, Excellus and BlueCross BlueShield of WNY

Common Codes:

01 – Discharged to Home or Self Care (Routine Discharge)

30 – Still patient or expected to return for outpatient services
FL 18-28

Condition Code

NOT REQUIRED

Please note: For WellCare outpatient claim that is within 72 hours of an inpatient claim require condition code to show that the service is not related to the inpatient claim. The outpatient claim is coded with condition code 51.

Except for Emblem, where situationally required
FL 29

Accident State

NOT REQUIRED, except for Emblem/Beacon which requires situationally.
FL 30

UNLABELED

NOT REQUIRED
FL 31-34

a & b) Occurrence Code/Date

NOT REQUIRED
FL 35 & 36

a & b) Occurrence Span Code/From/Through

NOT REQUIRED except for Emblem/Beacon which requires situationally
FL 37

a & b) UNLABELED

NOT REQUIRED
FL 38

Responsible Party Name/Address

NOT REQUIRED
a – d) Value Code

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by entering “24” followed immediately with the appropriate four digit rate code. Based on licensure or certification, programs submit one claim per rate code per day, per week, or per month.

REQUIRED - Please note:

- For Excellus (MMC, HARP, Essential Plan, and CHP), Empire Blue Cross Blue Shield HealthPlus & BlueCross BlueShield of WNY – Value Code must be followed by “00”
- For United – Value Code must be followed by “00” on the paper claim only; not the electronic submission. That include value code “24” under CODE
- Emblem Health/Beacon requires situationally
FL 40 & 41

a – d) Value Code

a – d) Value Code Amount

Since only one rate code per claim is allowed, additional rate codes are not required

NOT REQUIRED, with exception of Emblem Health/Beacon where can be situationally required
FL 42

Revenue Codes

REQUIRED
FL 43

Revenue Code Description/IDE Number/ Medicaid Drug rebate

NOT REQUIRED, with exception of Excellus which requires and Emblem Health/Beacon which requires situationally
Modifiers go in the same field as the procedure code. This field allows five digits for the procedure code and another 8 digits for modifiers, up to 4 modifier codes can be included with the procedure code. (See billing manual for required modifiers)

REQUIRED, please note Emblem Health/Beacon which requires situationally
FL 45

Service Dates

REQUIRED
FL 46

Service Units

REQUIRED
FL 47

Total Charges

REQUIRED
FL 48

Non Covered Charges

NOT REQUIRED, except Emblem Health/Beacon which requires situationally
FL 49

UNLABELED

NOT REQUIRED
FL 50

a) Payer Identification – Primary
b) Payer Identification – Secondary
c) Payer Identification – Tertiary

NOT REQUIRED, with exception of Emblem Health/Beacon, Excellus and United
FL 51

a – c) Health Plan Identification Number

NOT REQUIRED, with exception of Excellus

Please note: For United required for 837i submissions, not required for paper submissions
FL 52

a) Release of Information – Primary
b) Release of Information – Secondary
c) Release of Information – Tertiary

NOT REQUIRED, with exception of Emblem Health/Beacon
FL 53

a) Assignment of Benefits – Primary
b) Assignment of Benefits – Secondary
c) Assignment of Benefits – Tertiary

NOT REQUIRED, with exception of Emblem Health/Beacon
FL 54

a) Prior Payments – Primary
b) Prior Payments – Secondary
c) Prior Payments – Tertiary

NOT REQUIRED
FL 55

a) Estimated Amount Due – Primary
b) Estimated Amount Due – Secondary
c) Estimated Amount Due – Tertiary

NOT REQUIRED
a – c) Other Provider ID

NOT REQUIRED with exception of Emblem Health/Beacon which requires situationally
FL 58

a) Insured’s Name – Primary
b) Insured’s Name – Secondary
c) Insured’s Name – Tertiary

NOT REQUIRED, with exception of Excellus if name is different than subscriber and with Emblem Health/Beacon
FL 59

a) Patient’s Relationship – Primary
b) Patient’s Relationship – Secondary
c) Patient’s Relationship – Tertiary

NOT REQUIRED
FL 60

a) Insured’s Unique ID – Primary

Individuals Insurance ID Number

REQUIRED

b) Insured’s Unique ID – Secondary

c) Insured’s Unique ID – Tertiary

NOT REQUIRED, with exception of Emblem Health/Beacon which requires situationally
FL 61

a) Insurance Group Name – Primary
b) Insurance Group Name – Secondary
c) Insurance Group Name – Tertiary

NOT REQUIRED
FL 62

a) Insurance Group *Number* – Primary
b) Insurance Group *Number* – Secondary
c) Insurance Group *Number* – Tertiary

NOT REQUIRED
FL 63

a) Treatment Authorization Code – Primary
b) Treatment Authorization Code – Secondary
c) Treatment Authorization Code – Tertiary

NOT REQUIRED

Providers need to make sure that they obtain authorizations for services that require it, refer to UM guidelines.
FL 64

a – c) Document Control Number (DCN)

NOT REQUIRED with the exception of Excellus: situationally, if using the type of bill, fourth digit (frequency code) of 7 or 8 then this field is required. Should be the claim number previously processed, that is being replaced or voided.
FL 65

a) Employer Name (of the insured) – Primary
b) Employer Name (of the insured) – Secondary
c) Employer Name (of the insured) – Tertiary

NOT REQUIRED
FL 66

Diagnosis and Procedure Code Qualifier (ICD Version Indicator)

NOT REQUIRED with exception of Excellus, BlueCross BlueShield of WNY, Crystal Run, United Healthcare, and Emblem Health/Beacon
Principal Diagnosis Code

For claims which may not be directly related to a diagnosis, but for which a valid code is required to comply with the Implementation Guide, such as Child Care, Managed Care, and Waiver Services, NYS DOH will accept **ICD-10 code R69 – Illness, unspecified.**

**REQUIRED:** For United use F99 – mental disorder not otherwise specified

a – q) Other Diagnosis and POA Indicator

**NOT REQUIRED**
FL 68

UNLABELED

NOT REQUIRED
FL 69

Admitting Diagnosis Code

NOT REQUIRED except Fidelis which situationally requires
FL 70

a – c) Patient Reason for Visit Code

NOT REQUIRED except for WellCare and Excellus. Emblem Health/Beacon requires conditionally.
FL 71

Prospective Payment System (PPS)

NOT REQUIRED
FL 72

a – c) External Cause of Injury (ECI) Code and POA Indicator

NOT REQUIRED
FL 73
UNLABELED
NOT REQUIRED
FL 74

Principal Procedure Code/Date
a – e) Other procedure code/date

NOT REQUIRED
FL 75

UNLABELED

NOT REQUIRED
Attending Provider NPI and Qual

Attending Provider – Last Name/First Name

REQUIRED

For Paper Claims: For unlicensed practitioners without an NPI, the OMH (02249154) or OASAS (02249145) unlicensed practitioner ID may be used.

For Electronic/EDI Claims: To resolve issues for ACT, PROS, OMH Programs and OASAS Clinic and OASAS OTP claims:

- When submitting claims utilizing an unlicensed practitioner ID as Attending, providers will submit the NM1 Attending Provider Loop 2310A as follows:
  - NM108 and NM109 will be blank/not sent
  - REF Attending Provider Secondary Information will be added
  - REF01 G2
  - REF02 the OASAS or OMH unlicensed practitioner ID
    - (example: REF*G2*02249145~)
FL 77

- Operating NPI and Qual
- Operating Last Name/First Name

NOT REQUIRED, except Emblem Health/Beacon which requires situationally
FL 78

- Other Provider NPI and Qual
- Other Provider Last Name/First Name

REQUIRED for referring provider information

- ACT – May use Agency’s program NPI
- HCBS – Agency’s program NPI
- Children and Family Treatment and Support Services – the LPHA who makes the recommendation for services
- PROS – the LPHA who makes the recommendation for PROS
- For OASAS Services please refer to http://www.oasas.ny.gov/admin/hcf/documents/OPRAGuidance.pdf
FL 79

- Other Provider NPI and Qual
- Other Provider Last Name/First Name

NOT REQUIRED, except Emblem Health/Beacon which requires situationally
FL 80

Remarks

NOT REQUIRED, except Emblem Health/Beacon which requires situationally.
FL 81

a – d) Code-Code- QUALIFIER/CODE/VALUE

NOT REQUIRED with exception of Excellus and United Healthcare and Emblem which requires situationally. For United, the taxonomy code would be placed in this field.

Please note:

▶ For Excellus in first box, enter qualifier code B3 for field 56 billing provider taxonomy code. In second (and third, if applicable) boxes enter taxonomy code(s) for the field 56 billing provider.

▶ For Emblem in 81a, if qualifier code is B3 enter provider taxonomy code
Common Errors/Mistakes

1. Incorrect rate code (where applicable)
2. Authorizations not obtained
3. Total Charges Less Than Medicaid Rate
4. Type of bill for resubmission/rebilling
5. Modifiers Missing or Wrong
6. Site/Program not credentialed or on file
7. Eligibility – Member Not Part of Plan
8. Diagnosis
9. Timely Filing
10. Incorrect Client Information
11. Wrong Procedure Code or Place of Service
What To Do When Things Go Wrong?

1. Review internally
2. Gather information/data and be specific such as
   - Is this issue specific to a program/service
   - When did it start
   - What do you think the issue/problem is
   - Review the 277CA the “Claims Acknowledgement Report”: The 277CA acknowledges all accepted or rejected claims in the 837 file. This is prior to adjudication.
   - Review the 835, the “835 Health Care Payment / Advice”, also known as the Electronic Remittance Advice (ERA), provides information for the payee regarding claims in their final status, including information about the payee, the payer, the payment amount, and any payment identifying information.
What To Do When Things Go Wrong?

3. Try to determine if it’s internal process/set up issue or external
4. Review Billing Manual and Integrated Billing Guidelines to make sure you are meeting billing requirements
5. Review
6. Matrix – Managed Care Information
7. Contact Managed Care Organization
8. Provide data/information
Things You Can Do to Prepare

- Produce and monitor payer mix report based on EPACES information and not billing setup
- Develop a transformation team that will meet at least once a month if not bi-weekly. The team should include all areas of agency
- Develop internal communication plan
- Review current staffing titles to see if consistent with the transformation
Things You Can Do to Prepare

- Access—review current referral processes and see if they can be improved
- Financial systems—Review financial system to determine if they are set up to manage managed care billing
- IT/EHR—Review of IT/EHR systems
Tools

- **Managed Care Plan Matrix** – comprehensive resource for MCO contact information relevant to adults and children

- **Billing Tool** – Children System specific updates – coming soon!
Where to Submit Questions and Complaints

Questions and complaints related to billing, payment, or claims should be directed as follows:

• Specific to Medicaid Managed Care and for any type of provider/service: Managedcarecomplaint@health.ny.gov
• Specific to a mental health provider/service: OMH-Managed-Care@omh.ny.gov
• Specific to a substance use disorder provider/service: PICM@oasas.ny.gov
• Specific to an OPWDD provider/service: Central.Operations@opwdd.ny.gov
• General provider enrollment questions: providerenrollment@health.ny.gov
Questions and Discussion

Please send questions to: mctac.info@nyu.edu

Logistical questions usually receive a response in 1 business day or less.

Longer & more complicated questions can take longer.

We appreciate your interest and patience!

Visit www.ctacny.org to view past trainings, sign-up for updates and event announcements, and access resources.