Integrated Medicaid Managed Care Billing Guidance

Ambulatory Services
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Managed Care Technical Assistance Center (MCTAC) Overview

What is MCTAC?
MCTAC is a training, consultation, and educational resource center that offers resources to all mental health and substance use disorder providers in New York State.

MCTAC’s Goal
Provide training and intensive support on quality improvement strategies including business, organizational and clinical practices, to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.
Purpose / Goal of Day

• Reminder of key policy to support BH transition to Managed Care with an emphasis on: claiming and reimbursement policy.

• Walk through of claim components.

• Prompt conversations between providers / plans to begin claims testing
On-Going Work

- Integrated billing workgroup that includes representatives from OMH and OASAS providers, MCTAC, Coalition of BH Agencies, COMPA, ASAP, Health Plan Association to address systemic billing issues

- Providers are encouraged to work with plans directly on specific provider/claims issues.

- Providers can submit questions related to delivery of services through Medicaid Managed Care to:
  - OMH: OMH-Managed-Care@omh.ny.gov
  - OASAS: PICM@oasas.ny.gov
OMH/OASAS
Managed Care Billing Manual

- New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual For Individuals Enrolled in Mainstream Medicaid Managed Care Plans And HARP

Overall, BH Medicaid managed care implementation incorporates multiple administrative, fiscal, and clinical policies to promote a smooth transition to managed behavioral health.

Programs are encouraged to review:

- **The MRT webpage** for the foundational vision of integrating BH services into the managed care benefit package.
- **The recorded kick off presentation** for a full overview of the protective features specific to the integrated of BH services into the Medicaid managed care programs.
Introduction Continued

From a fiscal and administrative perspective these policies include but are not limited to:

1. Contracting requirements: (e.g. must contract where there are 5 or more enrollees; and, OTP are essential community BH providers so plans must offer all contracts)

2. Payment requirements: Plan must pay at the government rate for first 24 months (including APG rates)

3. Payment mechanism: Plans must utilize the 3M grouper or an exact replica to ensure proper payment

4. Claims submission for APG services: Generally follows the same claim construction as in FFS (e.g. rate codes / HCPCS / CPT and modifiers)

5. Plan Readiness: As part of an overall rigorous review process the plans must test and demonstrate readiness to process claims.
Electronic Claims: For OMH licensed clinics and OASAS Certified Clinics and OTP programs the state directed that plans must accept the 837 I AND must accept the APG rate codes; and the APG CPT / HCPCS codes and modifiers.

As such, for those OMH and OASAS outpatient programs currently utilizing 837 I the primary billing readiness activity will be learning what process each plan utilizes for the submitting the electronic claims.
Plans will accept the current modifiers utilized in the APG FFS claiming structure.

**OASAS:**
- All OASAS outpatient programs will be asked to include the HF modifier for tracking purposes, but plans may not deny for failure to include the HF modifier.
- OTP programs will continue to utilize the KP modifier for the first medication administration visit of the service week.

**OMH:**
- OMH Providers Should Utilize the Modifiers as specified in the billing manual.
Overview

• All Electronic claims will be submitted using the 837i (institutional) claim form

• UB-04 should be utilized when submitting paper claims

• Plans will be required to pay 100% of the Medicaid fee-for-service (FFS) rate (aka, “government rates”) for all authorized behavioral health procedures delivered to individuals enrolled in mainstream Medicaid managed care plans, HARPs, and HIV SNPs when the service is provided by an OASAS and OMH licensed, certified, or designated program.
Overview cont.

- When credentialing with OMH-licensed, OMH-operated and OASAS-certified providers, the Contractor (MCO) shall accept OMH and OASAS licenses, operation and certifications in place of, and not in addition to, any Contractor credentialing process for individual employees, subcontractors or agents of such providers. The Contractor shall still collect and accept program integrity related information from these providers, as required in Sections 18 of this Agreement, and 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.

- 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.
FL 01

Billing Provider Information

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

REQUIRED
FL 02

Billing Provider Designated Pay-To

- 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
FL 03

- a) Patient Control Number (member unique alpha-number control number assigned by provider)
  
  **REQUIRED:** Exception for United/Optum, Wellcare and Beacon

- b) Medical/Health Record Number
  
  **NOT required**
Type of Bill – 4 Digit Alphanumeric Code.

- 1\textsuperscript{st} Digit – 0 (leading 0)
- 2\textsuperscript{nd} Digit – Identifies the type of facility
- 3\textsuperscript{rd} Digit – Identifies type of care
- 4\textsuperscript{th} 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

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. 9 OTHER
3rd Digit (Special Facility Only)
1. Hospice (Nonhospital Based)
2. Hospice (Hospital Based)
3. Ambulatory Surgical Center Services to Hospital Outpatients
4. Free Standing Birthing Center
5. Critical Access Hospital
6. Reserved for National Assignment
7. Reserved for National Assignment
8. Reserved for National Assignment
9. OTHER

4th Digit-Frequency
1. Admit Through Discharge Claim
2. Interim-First Claim
3. Interim-Continuing Claims
4. Interim-Last Claim
5. Late Charge Only
7. Replacement of Prior Claim
8. Void/Cancel of a Prior Claim
9. Final Claim for a Home Health PPS Episode
FL 05

Hooks: 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 MMDDYYYY

REQUIRED
FL 07

› UNLABELED

NOT REQUIRED
FL 08

a) Patient Name

b) Patient Name

REQUIRED
FL 09

a) Patient Address- Street
   REQUIRED

b) Patient Address- City
   NOT required

c) Patient Address- State
   NOT required

d) Patient Address- ZIP
   NOT required

e) Patient Address- Country Code
   NOT required
FL 10

▷ Patient Birthdate

▷ The birth date must be in the format MMDDYYYY

REQUIRED
Patient Sex

REQUIRED
FL 12

 Admission Date/Start of Care Date

 NOT REQUIRED
FL 13

Admission Hour

NOT REQUIRED
FL 14

Priority (Type) of Admission or Visit

NOT REQUIRED
FL 15

Point of Origin for Admission or Visit (SRC)

NOT REQUIRED
FL 16

Discharge Hour

NOT REQUIRED
Patient Discharge Status

NOT REQUIRED with the exception of WellCare and Fidelis

Common Codes:
01 – Discharged to Home or Self Care (Routine Discharge)
30 – Still patient or expected to return for outpatient services

Please note this guidance applies to outpatient/ambulatory services only.
FL 18-28

Condition Code

NOT REQUIRED

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.

Please note this guidance applies to outpatient/ambulatory services only.
FL 29

Accident State

NOT REQUIRED
FL 31-34

▷ a & b) Occurrence Code/Date

NOT REQUIRED
FL 35 & 36

a & b) Occurrence Span Code/From/Through

NOT REQUIRED
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 -- For Empire Blue Cross Blue Shield HealthPlus – Value Code must be followed by “00”
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
FL 42

Revenue Codes

Please refer to Revenue Code Spreadsheet/Guidance for further information.

REQUIRED
FL 43

Revenue Code Description/IDE Number/ Medicaid Drug rebate

NOT REQUIRED
FL 44

CPT/HCPC/Procedure Code

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
FL 45

► Service Dates

REQUIRED
Service Units

Units of service to be used are listed on the coding taxonomy chart:
http://www.omh.ny.gov/omhweb/bho/coding-taxonomy.xlsx

REQUIRED
FL 47

Total Charges

REQUIRED
FL 48

Non Covered Charges

NOT REQUIRED
FL 49

UNLABELED

NOT REQUIRED
FL 50

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

NOT REQUIRED
FL 51

a – c) Health Plan Identification Number

NOT REQUIRED
FL 52

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

NOT REQUIRED
FL 53

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

NOT REQUIRED
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
FL 56

› NPI

Agency/Program NPI

REQUIRED
FL 57

a – c) Other Provider ID

NOT REQUIRED
FL 58

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

NOT REQUIRED
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
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
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
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
Principal Diagnosis Code

For claims which may not be directly related to a diagnosis, but for which a valid codes is required to comply with the Implementation Guide, such as Child Care, Managed Care, and Waiver Services, NYS DOH will accept ICD-9 code 799.9 – Other Unknown and Unspecified Cause; and after ICD-10 implementation, ICD-10 code R69 – Illness, unspecified.

For OTP Services: To facilitate claiming it is recommended these programs use ICD-10 for the entire week.

REQUIRED

a – q) Other Diagnosis and POA Indicator

NOT REQUIRED
FL 68

» UNLABELED

NOT REQUIRED
FL 69

Admitting Diagnosis Code

NOT REQUIRED

Please note this guidance applies to outpatient/ambulatory services only.
FL 70

▷ a – c) Patient Reason for Visit Code

NOT REQUIRED except for WellCare
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
1) Attending Provider NPI and Qual
2) 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

1) Operating NPI and Qual
2) Operating Last Name/First Name

NOT REQUIRED
FL 78

1) Other Provider NPI and Qual
2) Other Provider Last Name/First Name

REQUIRED for referring provider information

ACT – May use Agency’s program NPI
HCBS – Agency’s program NPI
PROS – the LPHA who makes the recommendation for PROS

For OASAS Services please refer to OPRA Guidance at:
FL 79

1) Other Provider NPI and Qual
2) Other Provider Last Name/First Name

NOT REQUIRED
FL 80

Remarks

NOT REQUIRED
FL 81

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

NOT REQUIRED
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
   1. Is this issue specific to a program/service
   2. When did it start
   3. What do you think the issue/problem is
   4. Review the 277CA the “Claims Acknowledgement Report”: The 277CA acknowledges all accepted or rejected claims in the 837 file. This is prior to adjudication.
   5. 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.

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
Links to OMH/OASAS Documents – Manual, Billing Manual and Fee Schedule


› Fee Schedule and Rate Codes: http://www.omh.ny.gov/omhweb/bho/phase2.html
Thank you for participating!

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

mctac.info@nyu.edu @CTACNY