Understanding Paper Claims Submission

For Billing and Finance Staff of Agencies New to Medicaid Managed Care Billing and Claims Submission

mctac THE MANAGED CARE TECHNICAL ASSISTANCE CENTER OF NEW YORK

July 8, 2019

Introduction & Housekeeping

Housekeeping:

- Chat questions in during the presentation
- Link to PDF UB-04 Billing Form is in the chat box
- Slides and recording will be posted at www.ctacny.org

Reminder: Information and timelines are current as of the date of the presentation

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Agenda

- Billing Basics and Readiness
- Revenue Cycle Management Basics
- Submitting a Paper Claim
- Walk-Through UB-04 Claim Form
- Troubleshooting
- Resources
- Questions

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Billing Basics and Readiness

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Different Ways to Bill

- Paper Claims
- Medicaid Managed Care Plan Portal
- Billing System/Clearinghouse
- Electronic Health Record

Electronic Claims Options

- Purchase a system for your organization. (Build)
- Pay for a service to handle your billing and related functions.(Buy)
- Collaborate with other providers to develop shared capacity.

Considerations

- Feasibility depends on volume of claims.
- As volume increases, monitor the need for a more comprehensive solution.
- Payment generally takes longer with paper claims. Consider electronic payment.
- How will related functions (e.g. scheduling, eligibility tracking, claims status) other than claims submission be handled?

Billing Prerequisites

- ❑ Designated Provider?
- ❑ Medicaid Provider?
- ❑ NPI numbers?
- ❑ Contracted with Plans?
- ❑ Credentialed with Plans?
- ❑ Service and billing manuals?
- ❑ Discuss your claims process with Plans?

Steps to Prepare

- Develop a team.
- Team members from across the agency not just fiscal! This is a program and quality assurance function as much as a fiscal one.
- Meet bi-weekly to monitor the process.
- Develop internal and external communication plans.

Steps to Prepare (Cont.)

- Review your financial system to determine if it is set up to handle billing for managed care.
- Create work flows with clear responsibilities and timeframes.
- Identify quality assurance steps throughout the process.
- Train and support staff.

Revenue Cycle Management Basics

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Revenue Cycle Defined

- 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.

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Revenue Cycle Management

- Brings together workgroups and staff who do not work together in any other context.
- Revenue generation is the cornerstone of fiscal viability.
- Prevent inefficiencies, errors, and oversights which can have a devastating impact.
- Align service priorities and fiscal/billing priorities.

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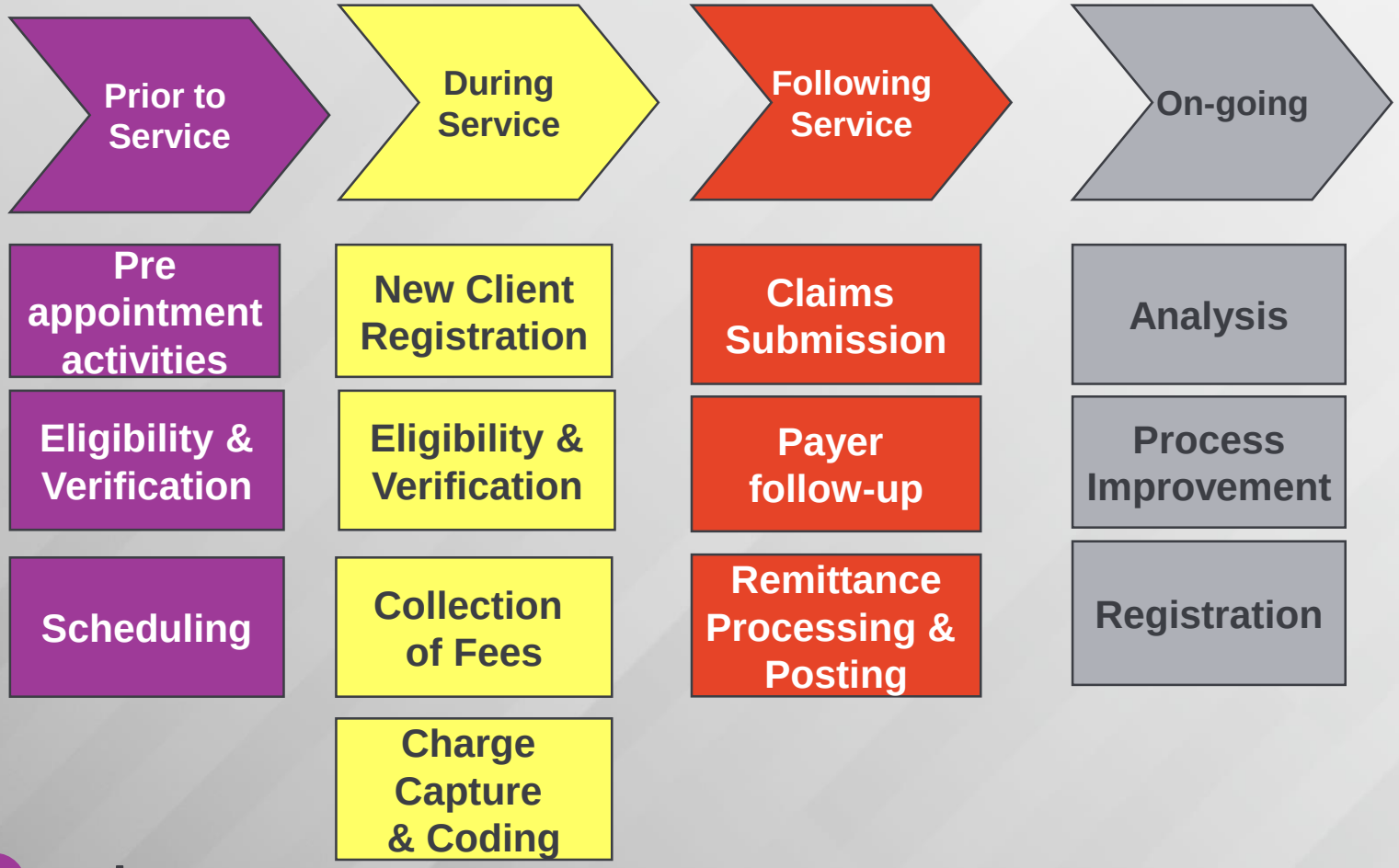
Phases of the Revenue Cycle



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MCO Tips for Successful RCM

- Train staff to complete UB-04 Form correctly.
- Review HIPAA requirements for claim submissions.
- Remember timely filing deadlines.
- Review and respond to remittance reports to allow time to make corrections and appeals.
- If claims are denied, promptly make corrections and resubmit.
- Sign up for electronic payments and statements.

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Submitting a Paper Claim

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Confirm Eligibility and Plan Enrollment

- Ask client for Medicaid card.
- Check Medicaid eligibility using ePACES.
- Confirm which Medicaid Managed Care Plan (MMCP) the client is enrolled in.

ePACES

Q: What is ePaces?

A: ePACES is the acronym for the Electronic Provider Assisted Claim Entry System, a web-based application which will allow Providers to create/submit claims and other transactions in HIPAA format. eMedNY developed this application on behalf of the NYS Department of Health.

Q: How do I enroll in ePaces?

A: ePACES Enrollment begins with issuance of a token and then responding to a series of emails generated by accessing the website https://www.emedny.org/enroll/. Call 800-343-9000 to obtain a token.

Q: How long does it take to enroll in ePaces?

A: The enrollment time frame is based on the provider's response time to multiple emails delivered through the enrollment process.

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Note: ePACES will be used to submit claims only for children whose status requires you to bill Fee-for-Service.

Form UB-04

Billing Overview

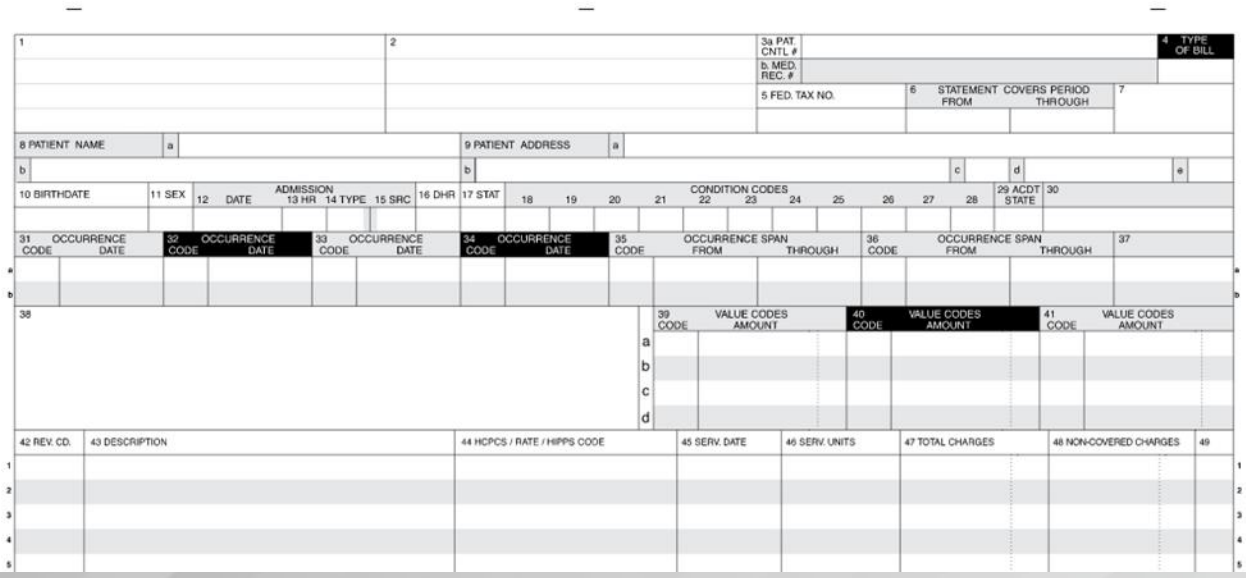
FORM UB-04

The MCTAC Billing tool is an interactive UB-04 form that walks through the components required to submit a clean claim. Whether you are new to the process or just want to quickly check one field, the billing tool is the ideal reference.

This tool will tell you what information is required for each field and will note specific plans' requirements.

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

Hover over or click each numbered field for more information.



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Submission Options

- Secure faxing
- Mail
- Entering information into the Medicaid Managed Care Plan's claims portal

Walk-Through the UB-04 Claim Form

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FL 01

Billing Provider Information

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

REQUIRED

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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
- United Healthcare
- Emblem Health/Beacon
- Excellus: Required when "pay to" entity is different than information in box 1

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FL 03

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

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FL 04

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

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FL 04 Cont.

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

FL 04 Cont.

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 treatment, for HHA PPS claims, indicates a Request for Anticipated Payment - RAP.) Note: For HHA PPS claims, CMS determines from which Trust Fund payment is made. Therefore, there is no need to indicate Part A or Part B on the bill.
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

FL 04 Cont.

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.

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

Federal Tax ID Number

Providers should not use a hyphen in the tax ID field

REQUIRED

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FL 06

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: 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**

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FL 07

NOT REQUIRED

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FL 08

a) Patient Name

b) Patient Name

REQUIRED

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FL 09

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

FL 10

Patient Birthdate

- The birth date must be in the format MMDDYYYY

REQUIRED

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FL 11

Patient Sex

REQUIRED

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FL 12

Admission Date/Start of Care Date

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

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FL 13

Admission Hour

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

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FL 14

Priority (Type) of Admission or Visit

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

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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

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FL 16

Discharge Hour

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

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FL 17

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

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FL 18-28

Condition Code

NOT REQUIRED

Please note: For WellCare outpatient claim that is within 72 hours of an inpatient claim requires 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

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FL 29

Accident State

NOT REQUIRED, except for Emblem/Beacon which requires situationally

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FL 30, FL 31, FL 32, FL 33, FL 34

NOT REQUIRED

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FL 35 & 36

a & b) Occurrence Span Code/From/Through

NOT REQUIRED except for Emblem/Beacon which requires situationally

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FL 37, FL 38

NOT REQUIRED

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FL 39

a – d) Value Code

a – d) Value Code Amount

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

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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

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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

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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, please note Emblem Health/Beacon which requires situationally

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FL 45

Service Dates

REQUIRED

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FL 46

Service Units

REQUIRED

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FL 47

Total Charges

REQUIRED

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FL 48

Non Covered Charges

NOT REQUIRED, except Emblem Health/Beacon which requires situationally

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FL 49

NOT REQUIRED

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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

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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

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FL 54 & FL 55

NOT REQUIRED

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FL 56

NPI

Agency/Program NPI

REQUIRED

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FL 57

a – c) Other Provider ID

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

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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

NOT REQUIRED

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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

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FL 61, FL 62 & FL 63

NOT REQUIRED

Providers need to make sure that they obtain authorizations for services that require an authorization

Refer to UM guidelines

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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

NOT REQUIRED

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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

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FL 67

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-10 code R69 – Illness, unspecified

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

a – q) Other Diagnosis and POA Indicator

NOT REQUIRED

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FL 68

NOT REQUIRED

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FL 69

Admitting Diagnosis Code

NOT REQUIRED except Fidelis which situationally requires

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FL 70

a – c) Patient Reason for Visit Code

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

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FL 71, FL 72, FL 73, FL 74 & FL 75

NOT REQUIRED

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FL 76

- **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

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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

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FL 79

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

NOT REQUIRED, except Emblem Health/Beacon which requires situationally

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FL 80

Remarks

NOT REQUIRED, except Emblem Health/Beacon which requires situationally

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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**
- **For Excellus 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**

Troubleshooting

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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. Ensure correct NPI number is listed
8. Eligibility – Member Not Part of Plan
9. Diagnosis
10. Timely Filing
11. Incorrect Client Information
12. Wrong Procedure Code or Place of Service

What To Do When Things Go Wrong?

- Try to determine if it's an internal process/set up issue or external.
- Review Billing Manual and Integrated Billing Guidelines to make sure you are meeting billing requirements.
- Communicate with MMC Plans to try to resolve before sending to the State. (See MMC Plan Matrix for MMCP contact information.)
- Review and provide information for any missing data.

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Resources

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Allowable Combinations

The following slides show allowable billing combinations.

It is important to be aware of all services your clients are receiving to avoid billing conflicts.

NYS Allowable Billing Combinations of Children's Behavioral Health, Children and Family Treatment and Support Services and HCBS

HCBS/State Plan Services	OMH Clinic	OASAS Clinic	OASAS Opioid Treatment Program	OMH ACT	OMH PROS*	OMH CDT*	OMH Partial Hospital	OASAS Outpatient Rehab	CPST / OLP	PSR	FPSS	YPST
Habilitation	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Caregiver & Family Support and Services	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Respite	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Prevocational Services	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

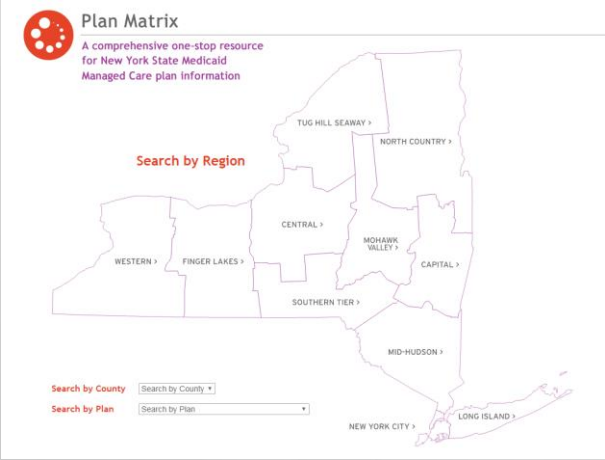
NYS Allowable Billing Combinations Children's Behavioral Health, Children and Family Treatment and Support Services and HCBS

HCBS/State Plan Services	OMH Clinic	OASAS Clinic	OASAS Opioid Treatment Program	OMH ACT	OMH PROS*	OMH CDT*	OMH Partial Hospital	OASAS Outpatient Rehab	CPST/OLP	PSR	FPSS	YPST
Supported Employment	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Community Self-Advocacy Training and Supports	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Other Licensed Practitioner (OLP)	No	No	No	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes
Community Psychiatric Supports and Treatment (CPST)	Yes	Yes	Yes	No	No	No	Yes	Yes	-	Yes	Yes	Yes
Psychosocial Rehabilitation (PSR)	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	-	Yes	Yes

NYS Allowable Billing Combinations of Children's Behavioral Health, Children and Family Treatment and Support Services and HCBS

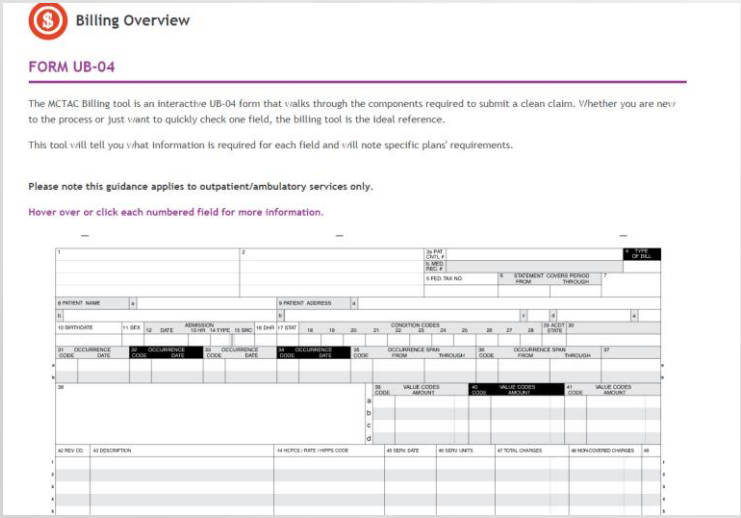
HCBS/State Plan Services	OMH Clinic	OASAS Clinic	OASAS Opioid Treatment Program	OMH ACT	OMH PROS*	OMH CDT*	OMH Partial Hospital	OASAS Outpatient Rehab	CPST/OLP	PSR	FPSS	YPST
Youth Peer Support and Training	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-
Family Peer Support	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-
Crisis Intervention	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Palliative Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Accessibility Modifications	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adaptive and Assistive Equipment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Tools



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

- **Billing Tool** – Children System specific updates –coming soon!



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Billing Manual

NYS Children's Health and Behavioral Health Services – Children's Medicaid System Transformation Billing and Coding Manual: Access Here

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Children's System Transformation Resources

- You can find links to provider manual, and guidance documents and other resources related to the Children's System Transformation on the CTAC website here.

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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

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