BRIEFING WEBINAR FOR OASAS CERTIFIED PROGRAMS ON THE STATUS OF MANAGED CARE CLAIMING

November 18, 2015
Agenda

• Opening remarks
• OASAS Overview of Process to Date
• MCTAC Initiatives Addressing Billing and Claiming
• Updates From The Plans – Beacon, Amerigroup and HealthFirst
• Update from Millin
• Response to Questions
Presenters

- Rob Kent – OASAS, General Counsel
- Pat Lincourt – OASAS, Division Director of Practice Innovation and Care Management
- Ilyana Meltzer – OASAS, Bureau Director, Practice Innovation and Care Management
- Carla Lisio – CASAColumbia/MCTAC
- Health Plan and Millin Representatives
Opening Statement

• Rob Kent – OASAS, General Counsel
OASAS Overview of Process to Date

- Pat Lincourt – Division Director Practice Innovation and Care Management

- Ilyana Meltzer – Care Management Bureau Director Practice Innovation and Care Management
MCTAC Initiatives

- Integrated Billing Guidance
- HCBS-Specific Billing Training in December
- Program Specific Billing Webinars – as needed, in development
- Involvement in a number of forums designed to stay current and address billing issues as they arise
Claims
Claims

• Make sure to register all sites with Beacon and keep us updated of changes
• Make sure to validate the member is eligible both through the plan and for the new services
• Make sure the claims you submit contain valid ICD 10 and DSM V codes
• Make sure you are using the correct NPI
• Make sure to submit claims within the plans timely filing limits
• Make sure you have an authorization file, if necessary
• Monitor any claim rejections and resubmit with corrections regularly
• Use our resources if you need assistance
Claims

- Make sure to use the correct Value Codes. These are needed for APG processing. Please reference MCTAC Billing Slides for more information.
- Make sure to use KP and HF modifiers as appropriate. Additional information can be found on p. 34 of the State Billing manual found at the link below. [http://www.omh.ny.gov/omhweb/bho/billing-services.html](http://www.omh.ny.gov/omhweb/bho/billing-services.html)
- Make sure to use correct form type. APG reimbursed services should be submitted on the 837i for electronic submissions and UB04 for paper submissions.
- Avoid submitting the same billing and rendering NPI
- Claims for medical issues such as lab and pharmacy should be billed to the Health Plan
- VNS and Emblem claims to be submitted directly to Value Options for faster processing. (being rerouted now)
• Provider Relations  844-265-7592

• Provider.Relations@beaconhs.com

• eServices Helpline   866-206-6120

• eServices email  eServices@beaconhs.com

• Claims Hotline 888-206-6120
Claims Experience

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Claims Findings and Lessons Learned

The revenue codes that the providers use do not match the revenue codes we have in our system.

OASAS providers submitting claims without rate codes resulting in denials.

Same codes used for different services with different authorization rules (example-H2019) causing challenges for providers who do not require auths for these services.

Will be helpful for providers to learn how to resubmit a claim so the system does not reject as a duplicate claim.

Work done by the plans led by MCTAC on claims has been very helpful and a great resource.

Would have been helpful to have started claims testing earlier in the process.
Managed Care Claiming Webinar for NYC OASAS Adult Providers

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Billing Without the Appropriate Rate Codes

- Outpatient Providers will input 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” and following that immediately with the appropriate **four digit rate code**.

Billing Without Modifiers for HCPCS Codes

- HCPCS Code H0002 – Behavioral health screening to determine admission eligibility for SUD –
  - Recommend that the HF modifier be used for purposes of data collection

ICD-10 Transition Issues

- The UB-04 Box 6 requires a date **after 10/1/15**
- Claims require appropriate ICD-10 codes

Resubmitting Denied Claims as “Duplicate” or “Corrected” Claims

- Additional training required on how to submit corrected claims via mail or provider portal
- Corrected claims submitted electronically are denied as a “duplicate”
From 10/1/2015 to 10/31/2015 we identified programming issues that lead to inappropriate claims denials.

Top 3 categories of inappropriate HF claims denials were:

- “Carved out services to the state”
- “Service Not in provider contract”
- “No Authorization/Service Not Authorized”

In addition, an underpayment issue was identified

- “Preventative Promotion/Incentive”: Providers were paid $10 instead of correct rate

These systems issues have been resolved

Clean claims were reprocessed on 11/16/2015

As we have learned of providers experiencing these issues, we have reached out directly to attempt to resolve them swiftly
Lessons Learned and Next Steps

What We Learned

✓ Communication is key
✓ It is important that providers reach out when they have questions or unexplained denials
✓ Educating providers is ongoing

Next Steps

✓ Leverage your dedicated Behavioral Health Representative...ask questions!
✓ Sign-up for the provider portal
✓ Refer to the Managed Care Billing Guidelines as needed
✓ Attend MCTAC trainings
Submit clean claims the first time around!

- Verify recipient’s Age
  - 21 or older – Bill Managed Care
  - 20 or younger – Bill Fee for Service

- Review County listing on eMedNY
  - NYC – Bill Managed Care
  - All others – Bill Fee for Service

- Submit the correct provider Address and Zip +4
  - Managed Care plans edit on the provider’s contracted service location(s)

- Include the accurate electronic Payer ID when submitting through a Clearinghouse
OASAS MANAGED CARE TRANSITION
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Claims Follow-Up and Accounts Receivable

• Carefully review Clearinghouse and Payer Validations for electronic claim submissions
  ❖ Know the difference between a real front-end rejection vs. a warning message

• Determine if payer remittances will return electronically (ERAs) or on paper, and establish workflows around it
  ❖ Have clearinghouse/payer enrollment forms been completed?
  ❖ Do the payer(s) have an agreement with the Clearinghouse to return ERAs?

• Review remittances to ensure payments are in accordance with Government APG rates
  ❖ CARC code CO45 typically will return on ERAs when the charge amount exceeds the payer’s allowed amount

• Maintain a record of submission dates to ensure claims don’t fall into a black hole

• Follow each payer’s guidelines for submitting replacement/adjustment claims
RESOURCES

- MCTAC Website: http://mctac.org/
- eMedNY Website: https://www.emedny.org/