NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

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Webinar Q and A
Transition Reports for Inpatient and Outpatient Denials September 18, 2015

OMH - OASAS - MCOs Webinar Frequently Asked Questions

Q1. **If the data source used for the submission doesn't include rate codes, how do we determine "Type of Inpatient Admission?"**

A1. There is currently no standard list of CPT procedure codes to define inpatient behavioral health service. New York State identifies the services through rate codes. All plans have protocols that identify inpatient behavioral health admissions such as specific level of care criteria and provider notification requirements. Plans also typically have dedicated UM staff that review and authorize these services. Plans should submit the requested data elements for all admissions identified as behavioral health according to each plan's internal protocols.

Q2. **If the plan does not have an "Address 2" to report, what do we put in there?**

A2. Because the file is a fixed length format, you need not enter anything in the field.

Q3. **In the "Address" field, is it necessary to remove all the commas?**

A3. No, since the file is in fixed length format, you need not remove commas or other delimiters in any alpha-numeric field.

Q4. **If the service was denied for a provider that is located outside of New York State, what do we put in for county code?**

A4. The specs instruction includes code "99" for "other" in the "county code" field. To identify the provider's location, there should be enough space to input the address in "address 1" and "address 2" fields. If out of space, street address and zip code should be sufficient.

Q5. **Couldn't you get all the provider's information from the NPI?**

A5. No, many providers use the same NPI for facilities located at different sites. We want the submissions to be as specific as possible in terms of service location. Some locations also have different service types, so be specific with their corresponding address information.

Q6. **In the inpatient report, if the provider offers four types of services, will they show up in the report four times?**

A6. Yes. The denials for each service are reported in separate rows.

Q7. **In the provider identifier section, do we report service provider or billing provider information?**

A7. All responses should indicate the provider at the site level, not the agency level. Report the service provider.

Q8. **If a provider has contracted with a plan for multiple lines of business, how is the provider reported?**

A8. The provider should appear in the file for each line of business for which the provider is under contract. The denials and authorizations are specific to the line of business.

Q9. **Are there any administrative denials for inpatient service?**

A9. For inpatient services, administrative denials are accounted for in different reason codes, for each denial type. For example, if the reason is "Member did not have current active coverage with the health plan", the health plan will report the denial counts under retrospective denial reason #6.g. The list of denial reasons is meant to be exhaustive and exclusive, and does not provide for an "Other" category.

Q10. **Is it possible for a submission to be corrected multiple times?**

A10. We will look for all the errors in the initial submission to avoid multiple corrections and resubmissions for the same month/quarter.

Q11. **If there is no denial for a provider (for inpatient submission), do we still report it?**

A11. Based on the suggestion of plans brought up in the webinar, plans will report all denial and authorization information for their contracted providers.

Q12. **If none of contracted providers have any denial, will plan still submit the denial files?**

A12. Based on the discussion with plans in the webinar, the health plan will submit the authorization information even if there are no denials to report.

Q13. **Are we to submit all the authorizations for all contracted providers each month?**

A13. Yes.

Q14. **Since we believe it's a totally different report (covering more than just denials) are we going to get new specs? And when will that be?**

A14. The additional reporting suggested by United and Beacon during the webinar on Friday, Sept 18, 2015, does not change the main purpose of the report – to monitor denials for inpatient behavioral health services based on medical necessity. There are no changes in the specs and the format of the report. There is no additional guidance and there is no change in the timeline for the report.

Additionally, the impact of listing all contracted providers and their denial and authorization counts is minimal to plans, who are using the same source data, and is minimal to the State, which will be uploading more data. Reporting the universe of all authorizations, as plans suggested, provides a complete picture of the number of denials at the provider level. From the State's perspective, looking at the universe does not minimize the significance of one denial when the service is medically necessary.

The slides sent out after the webinar to plans on Friday, September 18, have an added slide (#15) saying that plans suggested during the webinar that they should list all their contracted providers and the associated denial and authorization counts in the report, even when there are no denials for the particular provider for the reporting month. No representatives from other health plans objected to the suggestion.

Q15. **Are you going to match the submissions with the encounter data, considering the lag?**

A15. No, these submissions are there for the sole purpose of tracking denials at the provider level. It is not intended to tie them to encounter data.

Q16. **If there was an issue with just one row, can we resubmit one row instead of the whole file?**

A16. The process will be more efficient if the State sends the plan a list of submission errors, and for the plan to submit the entire file with the errors corrected.

Q17. **When is the first monthly submission and quarterly submission due?**

A17. The first monthly submission is due November 15, 2015, and the first quarterly submission is due January 15, 2016.

Q18. **Is there any timeline for upstate plans?**

A18. Not yet. The contracts are not in place. Plans will be advised of the timeline once it has been determined.