



# **Interim Clinic Claiming Methodology: Issues & Solutions**

**New York State Office of Mental Health  
44 Holland Ave., Albany, NY**

**October 6, 2010  
11:30 a.m. – 1:30 p.m.**

# Webinar Agenda

- Medicaid fee-for-service interim claiming and readjudication process
- Status of outstanding claiming issues:
  - Claiming for physician add-on
  - Claiming for new Part 599 services
  - Claiming off-site for:
    - Crisis intervention (for both adults and children)
    - Children's services
  - Medicaid State Plan amendment
- Identification of claiming issues posed by clinic software vendors
- Discussion of solutions

# Retroactive APG Claim Processing

## Summary of Instructions:

- From 10/1 until approval, OMH clinics bill using existing rate codes
  - 4301– 4306 and 4601–4606 and 4099
- Code all Part 599 procedures (CPT codes) and modifiers on all claims submitted under the old rates code.
- Once federal Medicaid approval is received, CSC will automatically reprocess these claims under the APG rate code
  - 4301 – 4306 claims reprocessed under APG rate code 1504
  - 4601 – 4606 claims reprocessed under APG rate code 1510
- Claims that successfully reprocess under the APG rate code will not need to be adjusted later by the provider to add “missing codes”.

# Retroactive Claim Processing

## Example: Single Claims

- Provider submits only one claim for a patient in a day
  - 4301 code will automatically be replaced by 1504.
  - Payment amount will be recalculated for all procedures and modifiers on the original claim under APGs, keeping the same claim number (TCN).
  - Medicaid payment for the cycle of the reprocessing will include any additional payment amount or any reduction.
  - **Any reduction will be taken in full in the applicable check unless special arrangements are made with the Department of Health.**

# Retroactive Claim Processing

## Multiple Same Day, Same Person Claims

- Two or more claims for a single patient for the same date of service (e.g., both 4301 and 4304)
  - CSC will separately reprocess these claims under APGs (under rate code 1504 in this case).
  - The claims will not be combined by CSC.
  - The first claim to be reprocessed (e.g., 4301) will have its rate code changed to 1504 and the payment will be recalculated.
  - Additional claims will “kick out” as duplicates since a claim has already processed under 1504.
  - **The previous payment for 4304 will temporarily stay with the provider.**

# Retroactive Claim Processing

Technical note for multiple same day claims with E/M codes:

- Use same diagnosis codes in the same order on both claims
  - Under APGs, diagnosis affects payment for E/M codes.
- Diagnosis related E/M should be primary diagnosis on both claims.

# Exceptions to Automatic Reprocessing

- Automatic reprocessing will not work for
  - Health Physicals – Need State Plan approval
  - Health Monitoring – Need State Plan Approval
  - Off-Site Children's - Instructions to come
  - Off-Site Crisis Services - Instructions to come
  - Physician Add-On – Instructions to come
- Hold claims for these services until further notice

# Billing Systems Unable to Submit Identical Procedures on Same Day Claims with Different Rate Codes: Example

- 4301 reprocesses first
  - Claim will be converted to 1504 with all of its procedures intact
  - Adjustment will be calculated under APGs.
- 4304 claim will then attempt to reprocess and will reject.
  - Will “kick out” as a duplicate claim under 1504 and will not reprocess.
  - The rejected claim will continue to exist as a 4304 claim
  - **The previous payment for 4304 will temporarily stay with the provider.**
- The result will be reflected in the provider’s payment for the cycle of the claim adjustment.

# **Billing Systems Unable to Submit Identical Procedures on Same Day Claims with Different Rate Codes: (cont)**

- Later, the provider adds all procedures and modifiers from the rejected 4304 claim to the already paid 1504 claim as adjustments.
- The rejected claim is voided.
  - Provider will still have the proceeds from the 4304 claim, so the provider should void that claim if the 1504 adjustment has processed correctly.
  - If provider does not void the rejected 4304 claim, it will eventually be voided by the eMedNY system when OMH zeroes out (end dates) all of the old rate codes.
- The 4304 payment will be recouped when the claim is voided.

# Another Alternative - ePACES

- The eMedNY ePACES system is an alternative when the provider's existing billing system cannot produce and submit two same day claims with same procedures and modifiers with different rate codes.
  - [http://www.emedny.org/selfhelp/ePACES/ePACES\\_GenerallInfo.html](http://www.emedny.org/selfhelp/ePACES/ePACES_GenerallInfo.html) 
- This alternative minimizes or eliminates the need for amended claims after reprocessing.
- Option 1: Submit all complete identical claims with different rate codes through ePACES.
- Option 2: Submit one complete claim with all of the procedures and modifiers through your current system and one identical claim with a different rate code through ePACES.

# Medicaid Managed Care

- Continue COPS-Only billing from October 1
  - Rate codes 4093-4098
- COPS-Only to be paid at 100% until federal approval of state plan
- Medicaid managed care “equivalent” rates will begin after CMS approval and are not retroactive.

# APG Procedure Code to Part 588 Rate Code Conversion

Part 599 Procedure	CPT Codes	Part 588 Service
Outreach	H0023	Not Reimbursable
Initial Assessment Diagnostic & Treatment Plan	90801	Full
Psychiatric Assessment - 30 mins	90805	Full
Psychiatric Assessment - 45-50 mins	90807	Full
Psych Assessment - Alt Codes New/Estab Patient	99201-99205 99212-99215	Full
Psychiatric Consultation - New/Estab Patient	99201-99205 99212-99215	Full
Crisis Intervention - 15 min	H2011	If 15 minutes then Brief or if 30 minutes then Full
Crisis Intervention - per hour	S9484	Crisis
Crisis Intervention - per diem	S9485	Crisis
Injectable Psychotropic Medication Admin	H2010	If 15 minutes then Brief
Psychotropic Medication Treatment	90862	Brief
Psychotherapy - Indiv 30 mins	90804	Full
Psychotherapy - Indiv 45 mins	90806	Full
Psychotherapy - Family 30 mins	90846	Collateral
Psychotherapy - Family&Client 1 hr	90847	Collateral
Psychotherapy - Family Group 1hr	90849	Group Collateral
Psychotherapy - Group 1 hr	90853	Group
Developmental Testing - limited	96110	If 15 minutes then Brief or if 30 minutes then Full
Developmental Testing - extended	96111	If 15 minutes then Brief or if 30 minutes then Full
Psychological Testing - Various	96101	If 15 minutes then Brief or if 30 minutes then Full
Psychological Testing - Neurobehavioral	96116	If 15 minutes then Brief or if 30 minutes then Full
Psychological Testing - Various	96118	If 15 minutes then Brief or if 30 minutes then Full
Complex Care Management - 15 mins	90882	Brief
Health Physicals - New/Estab Patient	99382-99387 99392-99397	Hold Claim
Health Monitoring - 15 mins	99401	Hold Claim
Health Monitoring - 30 mins	99402	Hold Claim
Health Monitoring - 45 mins	99403	Hold Claim
Health Monitoring - 60 mins	99404	Hold Claim
Health Monitoring Group - 30 mins	99411	Hold Claim
Health Monitoring Group - 60 mins	99412	Hold Claim
Physician's Fee Schedule		Hold Claim

<b>OMH Clinic Rate Code</b>	<b>Description</b>
<b>4301</b>	OMH CLINIC - REGULAR
<b>4302</b>	OMH CLINIC - BRIEF
<b>4303</b>	OMH CLINIC - GROUP
<b>4304</b>	OMH CLINIC - COLLATERAL
<b>4305</b>	OMH CLINIC - GRP COLLATERAL
<b>4306</b>	OMH CLINIC - CRISIS
<b>4601</b>	OMH CLINIC - REGULAR MC/SED
<b>4602</b>	OMH CLINIC - BRIEF MC/SED
<b>4603</b>	OMH CLINIC - GROUP MC/SED
<b>4604</b>	OMH CLINIC - COLLATERAL MC/SED
<b>4605</b>	OMH CLINIC - GROUP COLLATERAL MC/SED
<b>4606</b>	OMH CLINIC - CRISIS MC/SED

# Outstanding Issues

- Medicaid state plan amendment
  - OMH is waiting for federal approval
  - Claims for Health Monitoring and Health Physicals must be held until the state plan is approved
    - These are not Medicaid fee-for-service reimbursable under the current Medicaid State Plan and therefore cannot be reimbursed on an interim basis.
- Uncompensated care pool
  - OMH is waiting for federal approval
  - Once approval is received payments will be prospective and not retroactive.
- Claiming for physician add-on
  - Instructions for billing off the physician fee schedule being developed
    - Key issues include how to report Medicare received on the Medicaid claim
    - OMH and DOH are exploring the option of prospectively using a modifier for the physician add-on rather than the physician fee-schedule
- Claiming for offsite crisis and offsite children's services
  - Federal approval is not expected in the near-term for offsite services.
  - New York State will make state dollars available for offsite crisis and offsite children's services through the eMedNY system.
  - In the next few weeks, OMH and DOH will provide a separate rate code and instructions for billing these services.

# Discussion

- Identification of claiming issues and concerns