OMH
Ambulatory Patient Group (APG)

Billing Instructions

September 2010

Provider Billing Changes

- **New APG Rate Codes- Effective for Dates of Service (DOS) on XX/XX/2010**
  - **For listing of the new APG rate codes go to:**

  http://www.omh.state.ny.us/omhweb/clinic_restructuring/NYCRR_part_599_guidance.pdf

- **Continue to use Current Rate Codes until the APG implementation date.**
  - **However, starting on October 1, 2010 the use of APG *appropriate procedure codes* is essential (even when billing with current rate codes)**
  - **When the APG is implemented, all claims billed between 10/1/10 and the APG implementation date will be automatically adjusted.**

- **After the APG implementation, the current rate codes should be used for billing voids and adjustments for DOS prior to the APG implementation.**

- **Essentially, the minimum change required to bill and get paid after the APG implementation date is to use the new APG rate code rather than the existing rate code.**

Provider Billing Changes (cont.)

■ **Use new APG rate code (s)**

■ **Code and Bill to Medical Record Documentation**

➢Complete and accurate reporting

➢Procedure and diagnosis code(s)

■ **All services, within the same DOS and service category(rate code) must be billed together on a single claim.**

Editing Changes (Cont.)

■ **MMIS Edit 1136** – non-billable rate code

➢ **Rate Code invalid for clinic (Do not submit *Capital Add-on* rate codes)**

  o Edit explanation: http://www.emedny.org/hipaa/Edit_Error/DrillDown/edits/01136.html

▪ **HIPAA 835/277 Edit Mapping**

– Adjustment Reason Code 16: Claim/Service lacks information which is needed for adjudication

– Remit Remark Code M49: Missing/incomplete/invalid value code(s) or amount(s)

– Status Code: 463: NUBC value code(s) and/or amount(s)

Editing Changes (Cont.)

■ MMIS Edit 2081 – claim denial

➢"All APG claim lines paid zero"

➢Ungroupable lines

➢Paid zero lines

• Edit explanation: http://www.emedny.org/hipaa/edit_error/DrillDown/edits/02081.html ⧉

▪ HIPAA 835/277 Mapping

– Adjustment Reason Code 125: Payment adjusted due to a submission/billing error(s)

– Remit Remark Code N19: Procedure incidental to primary procedure

– Status Category code F1: Finalized/Payment. Claim line has been pd.

• Claim Status Code: 65: Claim Line Has Been Paid

Processing Changes (Cont.)

■ **Allocating Medicare/Other Insurance:**

➢ *Deductible, Coinsurance, Co-pays*

  – Allocation applies only if reported on claim header

■**Total amounts are allocated from claim header to claims lines by:**

➢Sum of APG payments for all lines

➢ Divide **Individual** line payments by Sum of all line payments = line percentage

➢Then header amount is allocated to each paid line by the percentage

Remittance Changes

■ **835 *Supplemental files* will contain line level detail – one record for each line**

■ Line Level processing of APG claims

  ➢Line level COB

  ➢Line level detail included in remittances

■ **835 Changes contain;**

  ➢Line level detail

  ➢New data elements

• To access 835 information:

• http://www.emedny.org/hipaa/emedny_transactions/835/835_CG.pdf ⬀

Remittance Changes (Cont.)

■ **New 835 Remittance Data elements in Loop 2110:**

- APG Code – REF02 Qualifier 1S

- APG Full Weight – QTY02 Qualifier ZK

- APG Allowed Percentage – QTY02 Qualifier ZL

- APG Paid Amount – AMT02 Qualifier ZK

- Existing Operating Amount – AMT02 Qualifier ZL

- Combined With CPT – SVC06-2 Qualifier HC

- Line Number – REF02 Qualifier 6R

- CPT – SVC01-3 Qualifier HC

- Capital Add-on amount – CAS CO94

- Zero paid line (amounts bundled to highest weight line) – CAS CO97. The line amount is added as adjustment in OA94

- Total payment for claim – CLP04

Remittance Changes (Cont.)

■ **Paper remittance example (on next slide)**

- ▪ Total paid TCN above line payments
- ▪ New data elements indented for easier reading
- ▪ "Combined With CPT" links packaged CPT to significant procedure

Remittance Changes (Cont.)

MEDICAID
MANAGEMENT
INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
REMITTANCE STATEMENT

PAGE	02
DATE	08/27/2010
CYCLE	1723

TO: ABC MENTAL HEALTH SVCS
P.O. BOX 999
ANYTOWN, NEW YORK 11111

ETIN:
CLINIC-APG
PROVIDER ID/NPI: 00987654/0123456789
REMITTANCE NO: 100083000001

OFFICE ACCOUNT NUMBER	CLIENT NAME	CLIENT ID	TCN	DATE OF SERVICE	RATE CODE	CHARGED	TOTAL PAID	STATUS	ERRORS
CPT ①	APG ②	COMBINED WITH CPT ③	FULL WEIGHT APG AMOUNT ④	PCT APG WEIGHT ⑤	APG PAID ⑥	CAPITAL ADD ON ⑦	EXISTING OPERATING COMPONENT ⑧		

⑨

⑩

TCN: 10270-000000000-2-0   TOTAL PAID: 184.19

1234567890	Bill Smith	AB12345C	10270-000000000-2-0	12/01/2008	1504	200.00	70.75	PAID	
H2010	00490		.41380	90	56.26	14.49	0.00		
1234567890	Bill Smith	AB12345C	10270-000000000-2-0	12/01/2008		100.00	113.44	PAID	
90804	00315		.62060	100	23.44	00.00	90.00		

The paid amount for the claim is determined by the sum of the APG Paid $79.70 (The amounts in column 6 already reduced to 25% in year 1 for Blend codes), plus the sum of the Existing Operating Component $120.00 (The EOC amount in column 8 is already reduced to 75% for year 1 for Blend codes), plus the Capital Add-on amount in column 7, when applicable, plus any reductions = Total Paid for TCN $184.19.

NEW APG DATA ELEMENTS:

1.	CPT: Reported procedure code	2.	APG: APG code assigned by grouper
3.	Combined With CPT: Pointer to other significant procedure that caused the packaging and therefore zero payment on this line **(Not Applicable to OMH clinics.)**	4.	Full Weight APG Amount: Assigned grouper weight
5.	PCT APG Weight: Related to grouper assigned Payment Action Code. This is additional weight factor applied to Full Weight	6.	APG Paid: If a "Blend" code APG Paid Amount is the amount after the 25%, 50% or 75% is applied over each of the first three years. If "Full" code then no blend percentage applied.
7.	Capital Add-on: Amount added to Claim Payment.	8.	Existing Operating Component: Amount added to payments after the 75%, 50%, 25% is applied over each of the first 3 years and disbursed over paid lines. May be 0.00 if "Full" code.
			a. Figure above EOC -Total line payment - includes reductions for Medicaid co-payments, reported or prorated/bundled other insurance payments and prorated spend downs, if any. Total line payments will equal Total TCN paid amount.
9.	Total Paid TCN: Total Claim Payment	10.	Rate Code: Will appear only on line 1 of claim

Provider Testing Environment (PTE)

■ Test System Available 24X7

■ Test Environment will support the following transactions:
- 835 Remittance Advice 270/271 Eligibility
- 837 Claims (Inst, Prof, Dental) 278 PA & Service Auth. (SA)

■ Test Submissions
- 50 Claims per file (50 CLM segments)
- Test files (submitted & retrieved) using established communication method
- Test indicator on incoming file "T" ISA15

Provider Testing Environment (PTE – Cont.)

■ Test Remit Delivery

  ▪ Test Remit delivered in providers' production method (eXchange, iFTP, Paper or FTP)

  ▪ Weekly Test cycle close Fridays 2 PM –remits available on following Monday

  ▪ Test indicator "T" ISA15

  ▪ Test 835 and Supplemental remit files contain "T"

  ▪ Paper remits "TEST" has watermark on each page

■ Testing Process

  ▪ No history editing (no adjustments or voids)

  ▪ No 'pend' edits

  ▪ No editing for PA or SA

Contact Information

- Grouper/Pricer Software Support
  - *3-M Health Information Systems, Inc.*
    - *Grouper / Pricer Issues 1-800-367-2447*
    - *Product Support 1-800-435-7776*
  - *www.3mhis.com* ↗
- Billing Questions
  - *Computer Sciences Corporation*
    - *eMedNY Call Center 1-800-343-9000*
  - *eMedNYProviderRelations@csc.com*
- Policy and Rate Issues
  - *New York State Office of Mental Health*
  - *http://www.omh.state.ny.us/omhweb/clinic_restructuring/*

Conclusion:

Questions?