



September 17, 2010

Dear Clinic Provider

As you may know, OMH and DOH do NOT expect CMS to approve the amendment to NYS Medicaid Plan for OMH licensed mental health clinics prior to October 1. As a result, while Part 599 program regulations **will go into effect on October 1**, mental health clinics will **NOT** transition to APG claiming until CMS approval has been received. Once federal approval is received, claims for services delivered after October 1 will be automatically reprocessed under APGs.

Attached you will find two sets of instructions:

1. Interim Claiming Instructions for Part 599. These describe how the new 599 procedures should be claimed to Medicaid until federal approval is received.
2. Instructions for Test Billing APGs. These describe how to submit APG test claims to the eMedNY system.

We will be sharing more information as it becomes available.

Sincerely;

Norman Brier
Director of Financial Planning

Interim Claiming Instructions for Part 599

At this time, OMH and DOH do NOT expect CMS to approve the amendment to NYS's Medicaid Plan for OMH licensed mental health clinics prior to October 1. As a result, while Part 599 program regulations will go into effect on October 1, mental health clinics will NOT transition to APG claiming until CMS approval has been received. Once federal approval is received, claims for services delivered after October 1 will be automatically reprocessed under APGs.

During this interim period, DOH and OMH have developed a procedure to allow mental health clinics to continue to claim Medicaid reimbursement using the existing rate codes. With few exceptions, these claims will automatically (i.e., without additional provider submissions) readjudicate to pay the amounts anticipated under APGs AFTER CMS approves the SPA.

Until further notice from OMH or DOH, clinics will continue to claim Medicaid using rate codes 4301-4306 and 4601-4606, as appropriate. At least one of the procedures on a claim must meet the time requirements for one of the services under the CURRENT clinic regulations (Parts 587/588).

IMPORTANTLY, clinics must enter on each of its claims ALL OF THE CORRECT PROCEDURE (CPT) CODES delivered each day pursuant to the codes described in Part 599. In addition, clinics should enter any applicable modifiers.

Until the SPA is approved, eMedNY will pay all claims according to the current Medicaid "rules". The State will treat these payments as "interim payments".

When the SPA is approved, DOH will reprocess all claims for services delivered on or after October 1 with the "old" rate codes" to pay the difference between the interim amounts already paid and the payments due under the APG system. This may result in additional payment for any service day or may result in a "recoupment" for any service day. Clinics will receive the "net" adjustment after claims are readjudicated.

There are several important "caveats" to the readjudication described above.

First, each APG claim will include only one rate code. Therefore, all Medicaid fee-for-service claims for the "physician's add-on", "health physicals", "health monitoring", "off-site children's and offsite crisis services" must be held and submitted AFTER CMS approves the SPA. These additional payments are paid using rate codes other than those that will be automatically readjudicated. eMedNY will not recognize these claims until the SPA is approved. If they are submitted before the SPA is approved, they will be denied and NOT automatically readjudicated.

Second, the readjudication will pay only ONE APG claim per day, as will be the ongoing "rule" under APGs. This means that when clinics submit more than one claim during this interim period (e.g., an individual and collateral claim), **ALL Part 599 procedures must be included on BOTH interim Medicaid claims.** This will permit eMedNY to readjudicate one of these claims at its maximum value and deny payment for the second claim during the readjudication process without the clinic having to amend either claim.

Third, undoubtedly clinics will discover that even with automatic readjudication some payments are not exactly as anticipated. Clinics will be able to submit amendments to the readjudicated claims to correct any omissions or errors.

The following table can be used as a guide when completing an interim Medicaid claim.

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 |

Instructions for Test Billing APGs

OMH and DOH have “posted” draft APG base rates AND “blend rates” for your use to TEST the APG billing system prior to implementation of the new APG reimbursement system. Providers are strongly encouraged to submit APG test claims. The following are important provisos regarding these rates and next steps:

1. Test rates are NOT the final rates. They are still being calculated.

The “peer group base rates” are likely to remain what they are on the OMH APG “weight and rate chart” http://www.omh.ny.gov/omhweb/clinic_restructuring/cpt_proc_weight_rate_sched.xls. An individual clinic’s base rate will, based on the latest approvals, either include or exclude the QI add-on. If any clinic believes that upon receipt of its “test” remittance statement, it should have received the base rate inclusive of the Quality Improvement (QI) add-on, please fax (518-473-8255) or e-mail (cofplja@omh.state.ny.us) a copy of the QI approval letter to the Bureau of Financial Planning.

The blend rates are provider specific. They are calculated using July 1, 2008 to June 30, 2009 fee-for-service Medicaid paid claims excluding the COPs-only claims and claims that included payments from Medicare or any 3rd party insurer. The blend rates are the average reimbursement for each Medicaid reimbursed unit of service during this period inclusive of:

- Regular fee-for-service, reflecting different payments for different rate codes
- QI payments
- Payments for “Children Evenings and Weekends”
- COPs payments (adjusted for the COPs rate in effect June 30, 2009 or after)
- CSP payments up to the threshold amount effective July 1, 2009

These payments are summed and divided by the number of weighted Medicaid reimbursed service days/visits from July 2008 through June 2009.

For D&TCs that historically received a “capital rate”, the capital rate is INCLUDED in the “base reimbursement” for the purpose of calculating the “blend rate”. With the commencement of APG reimbursement, OMH licensed mental health clinics operated by D&TCs will NO LONGER be receiving a capital rate in addition to the operating rate.

For hospital-based OMH licensed mental health clinics, the capital rate(s) applicable for the period July 2008 through June 2009 will be EXCLUDED from the “base reimbursement”. These clinics will continue to receive a provider-specific capital rate in addition to their peer group base rate and “blend rate”.

For providers subject to the Tier III COPs rate reduction on June 30, 2009, OMH will restore the COPS rate for the purpose of the calculating the blend rate. Prospectively, clinics who are issued licenses with durations of less than six (6) months will have their rates reduced as described in Part 599.

The final blend rates for each clinic provider should be available, posted on the web-site and mailed directly to each provider by the middle of September.

2. CSP rates

As described in #1, above, the blend rate will include CSP for mental health clinics NOT operated by general hospitals. However, during the multi-year APG transition, the blend rate is paid at 75% in Year 1, 50% in Year 2 and 25% in Year 3. In order to maintain the full value of the CSP payment, the CSP balance will be paid using the “capital rate” add-on. Non-hospital clinics will not receive a true capital rate. Use of the capital rate for CSP reimbursement is a clinic-friendly means to maintain the full value of CSP revenue to the eligible clinics WITHOUT requiring clinics to submit a separate Medicaid claim for the balance of the CSP not paid through the blend payment.

OMH will continue to reconcile each clinic’s total CSP receipts against its approved “threshold” amount, and recoup any overpayment or advance any underpayment either through a future rate adjustment or recoupment of any balance due.

3. Medicaid Managed Care “Fee for Service” Rates” and COPs-only Rates

New York State has enacted legislation requiring that Medicaid Managed Care insurers reimburse providers at rates “equivalent” to the fee-for-service Medicaid rates for authorized mental health clinic services. This requirement will not be effective until AFTER the clinic Medicaid State Plan Amendment (SPA) is approved.

The legislation also allowed that “equivalent rates” may be LESS than the “government rate” if OMH has insufficient appropriation to support the full government rate. It has NOT YET BEEN determined if OMH can support 100% of the government rate or something less than 100%.

Lastly, at least through October 31st, clinics may continue to claim COPs only @ 100% of the COPs only rate. At this time, if CMS has not approved the Medicaid State Plan Amendment for OMH clinics, OMH plans to reduce the COPS only rate to 75% of the current COPs rate. The COPs only rates will be discontinued effective the date that “equivalent rates” are implemented.

Additional information on “equivalent rates” will be distributed as soon as more detailed information is available.

4. Service days/Visits

Under APGs, Medicaid will pay no more than one “blend” payment per service day, without regard to the number of blend eligible procedures delivered on any day. Because it is OMH’s intent that each provider that delivers the same number of reimbursed contacts receives 75% of its blend, in Year 1, 50% in Year 2 and 25% in Year 3, the blend calculation was adjusted to count each provider’s actual number of service days rather than the actual number of countable paid claims.

Nearly 6% of all clinics’ service days had two or more legitimately reimbursable Medicaid paid claims. They were not evenly distributed among clinics. Most of the days with more than one paid claim were days during which there was a client visit and a collateral visit. Under current reimbursement rules, both of these claims received applicable COPs and CSP payments. The adjustment to the calculation will provide the projected value of the blend if the pattern and number of reimbursable contacts are continued.

(The final blend rates expected to be published by mid-September will reflect the provider-specific adjustment for days during which more than one service was reimbursed by Medicaid.)

Procedure for Testing Claims

The following bullets summarize how to test bill claims. More complete instructions can be found on the DOH website at

http://www.emedny.org/hipaa/emedny_transactions/Technical/eMedNY_Provider_Testing_User_Guide.pdf 

- 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 are submitted & retrieved using established communication method
 - Test indicator on incoming file is “T” ISA15
- 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 prior approvals or service authorizations