Managed Care
Community of Practice
Preparing the I/DD Field for Managed Care

Community First Choice Option (CFCO) Billing Webinar

September 24th 2019

NEW YORK
ALLIANCE FOR INCLUSION & INNOVATION

The Managed Care Community of Practice is a project of the New York Alliance for Inclusion & Innovation in partnership with the following organizations

McSILVER INSTITUTE
FOR POVERTY POLICY AND RESEARCH

NYU SILVER SCHOOL OF SOCIAL WORK

Introduction and Housekeeping

- Slides and recording will be posted to www.mc-cop.com
- Reminders:
  - Information and timelines are current as of the date of the presentation.
  - This presentation is not an official document. For full details please refer to the provider and billing manuals.

Agenda

- Billing Basics and Readiness
- Revenue Cycle Management Basics
- Billing Procedures and Rules
- Troubleshooting
- Questions

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Billing Basics and Readiness

Claim Submission

Electronic claims will be submitted using the 837i claim form to both Medicaid FFS and Medicaid Managed Care.

Paper claims (UB-04) and web-based claiming will also be accepted by MMCPs.

Different Ways to Bill

- Paper Claims
- Medicaid Managed Care Plan Portal
- Billing System/Clearinghouse
- Electronic Health Record

Electronic Claims Options

- Purchase a system for your organization.
- Pay for a service to handle your billing and related functions.
- Collaborate with other providers to develop shared capacity.

Considerations

- Feasibility depends on volume of claims.
- As volume increases, monitor the need for a more comprehensive solution.
- Payment generally takes longer with paper claims. Consider electronic payment.
- How will related functions (e.g. scheduling, eligibility tracking, claims status) other than claims submission be handled?

Steps to Prepare

- Develop a team.
- Team members from across agency not just fiscal! This is a program and quality assurance function as much as a fiscal one.
- Meet bi-weekly to monitor the process.
- Develop internal and external communication plans.

Steps to Prepare (Cont.)

- Review financial system to determine if it is set up to handle billing for managed care.
- Create work flows with clear responsibilities and timeframes.
- Identify quality assurance steps throughout the process.
- Train and support staff.

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Revenue Cycle Management Basics

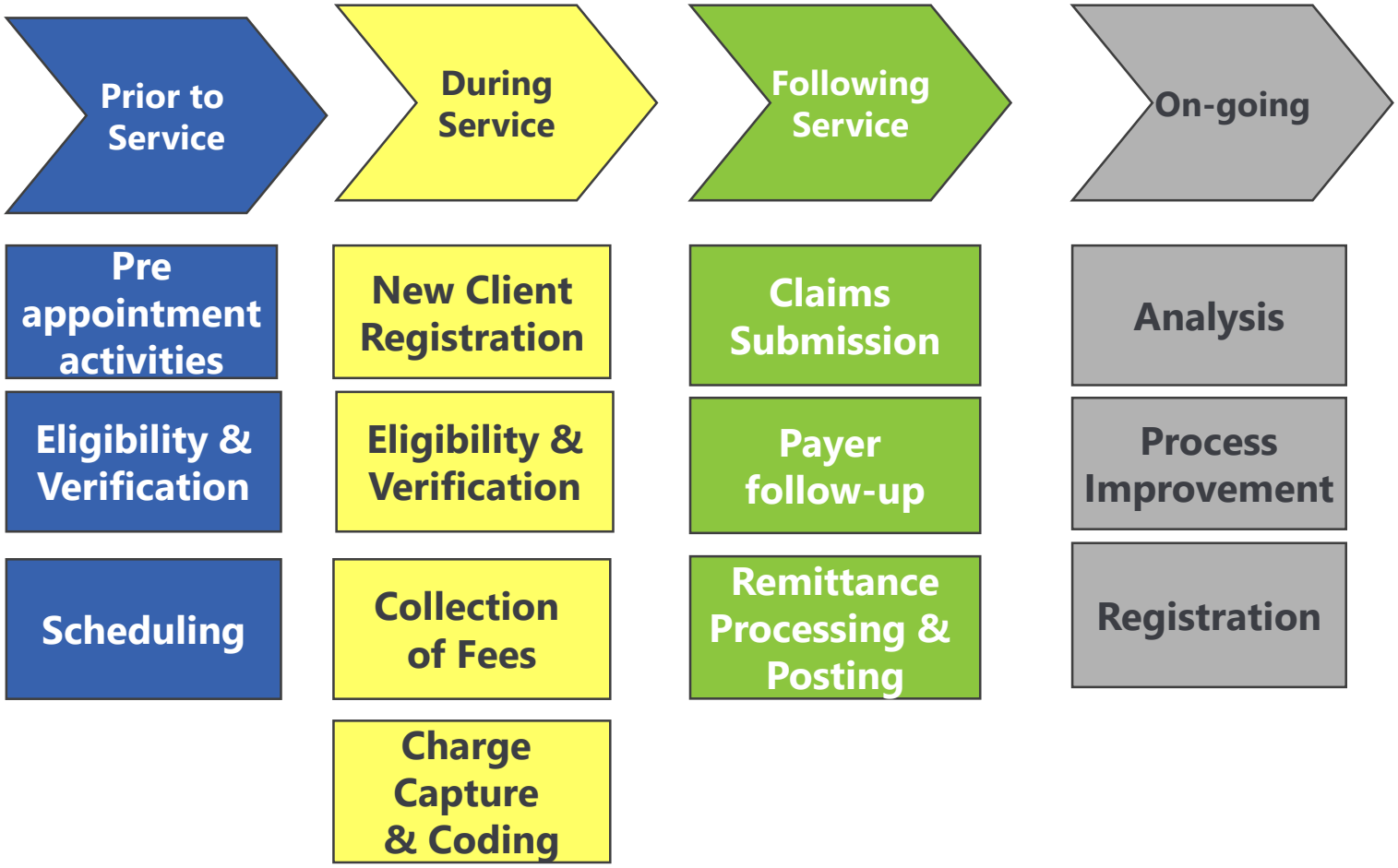
Revenue Cycle Defined

- All administrative and clinical functions that contribute to the capture, management, and collection of client service revenue.
- This describes the life cycle of a client account from creation to payment collection and resolution.
- The client account cycle is supported by a number of additional activities necessary to assure that all encounters are billable, meet regulatory requirements and revenue collection is maximized.

Revenue Cycle Management

- Brings together workgroups and staff who do not work together in any other context.
- Revenue generation is the cornerstone of fiscal viability.
- Prevent inefficiencies, errors, and oversights which can have a devastating impact.
- Align service priorities and fiscal/billing priorities.

Phases of the Revenue Cycle



MCO Tips for Successful RCM

- Train staff to complete UB-04 Form correctly.
- Review HIPAA requirements for claim submissions.
- Remember timely filing deadlines.
- Review and respond to remittance reports to allow time to make corrections and appeals.
- If claims are denied, promptly make corrections and resubmit.
- Sign up for Electronic Payments and Statements.

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Billing Procedures and Rules

Form UB-04

Billing Overview

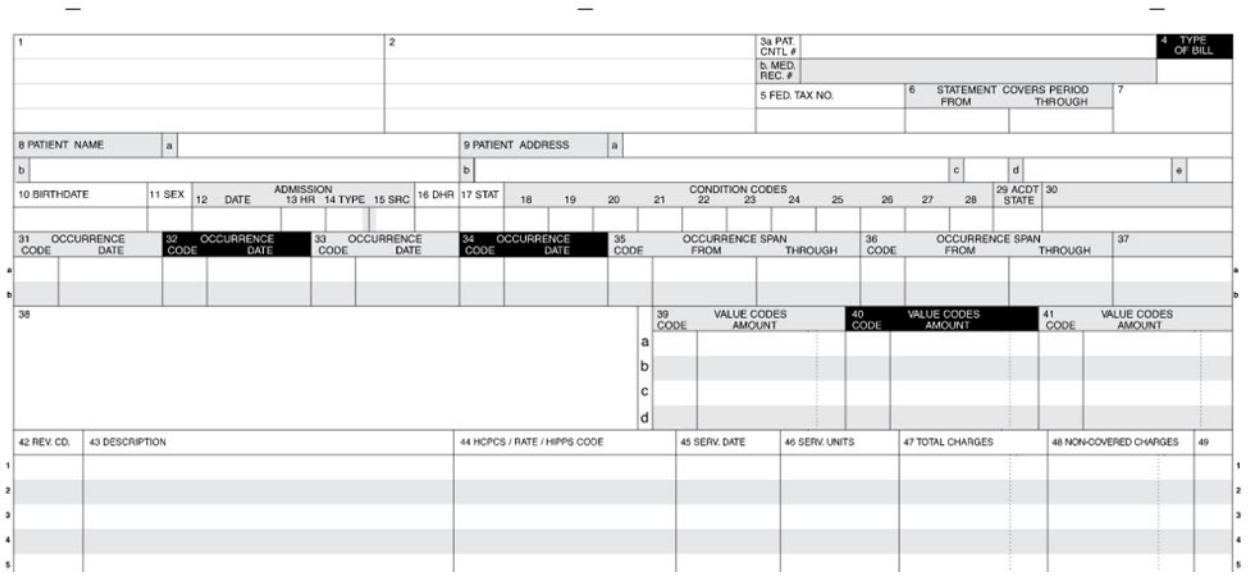
FORM UB-04

The MCTAC Billing tool is an interactive UB-04 form that walks through the components required to submit a clean claim. Whether you are new to the process or just want to quickly check one field, the billing tool is the ideal reference.

This tool will tell you what information is required for each field and will note specific plans' requirements.

Please note this guidance applies to outpatient/ambulatory services only.

Hover over or click each numbered field for more information.



Field 4

Suggest providers use one of the following combinations for initial claim.

0341

0 – Leading 0

3 – Home Health Facility

4 – Other Part B

1 – Initial Claim

0891

0 – Leading 0

8 – Special Facility

9 – Other

1 – Initial Claim

For "rebill" claims please substitute the 4th digit from 1 to 7

Field 39

Value Code

Providers will enter the locator code in the header of the claim as a value code. This is done in the value code field by entering “61” followed immediately with the appropriate three digit locator code.

Based on licensure or certification, programs submit one claim per rate code per claim.

Field 40

Value Code

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by entering “24” followed immediately with the appropriate four digit rate code.

Based on licensure or certification, programs submit one claim per rate code per claim.

Field 42

Revenue Code: 0240

Field 44 CPT/HCPC

Assistive Technology:

Rate codes 4482-4485 use T2028 HCPC code

Rate codes 3167-3170 (vehicle modification) use T2039 HCPC code

Environmental Modification: Use S5165 for all rate codes

Moving Assistance and Community Transition Services : T2038

Community Habilitation: H2014

Field 46 Service Units

Assistive Technology:

- Rate code 4482: Units <10
- Rate code 4483: Units <10
- Rate code 4484: Units <10
- Rate code 4485: Units <100

- Rate code 3167: Units <10
- Rate code 3168: Units <10
- Rate code 3169: Units <10
- Rate code 3170: Units <100

Field 46 Service Units Cont.

Environmental Modification

- Rate code 4476: Units <10
- Rate code 4477: Units <10
- Rate code 4478: Units <10
- Rate code 4479: Units <100

Field 46 Service Units Cont.

- Moving Assistance and Community Transitional Services: Units <100

- Community Habilitation: Units <97

Field 56

NPI Agency/Program NPI

Not Required

Field 57

Other Provider ID

Use Agency Medicaid Provider ID

Field 67

Principal Diagnosis Code

Required see attached document:

Field 76

- **Attending Provider NPI and Qual**
- **Attending Provider – Last Name/First Name**

Not Required

Field 78

- **Other Provider NPI and Qual**
- **Other Provider Last Name/First Name**

Not Required

Field 81

Code-Code- QUALIFIER/CODE/VALUE

Not Required

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Troubleshooting

Common Errors and Mistakes

1. Incorrect rate code
2. Total charges less than Medicaid rate
3. Type of bill for resubmission/rebilling
4. Site/Program not credentialed or on file
5. Eligibility – Member not part of plan
6. Diagnosis
7. Timely filing
8. Incorrect client information
9. Wrong procedure code or place of service

What to do when things go wrong?

- Try to determine if it's internal process/set up issue or external.
- Review Billing Manual and Integrated Billing Guidelines to make sure you are meeting billing requirements.
- Communicate with MMC Plans to try to resolve before sending to the State. (See MMC Plan Matrix for MMCP contact information.)
- Review and provide information for any missing data.

Upcoming Events

Preparing for the CFCO Transition to Managed Care In-Person Regional Trainings	
Albany	October 15th 9:30 AM – 3:30 PM
Rochester	October 17th 9:30 AM – 3:30 PM
NYC	October 29th 9:00 AM – 3:00 PM

Register at www.mc-cop.com/in-person-events

Question & Answer

- Please continue to submit your questions in the chat box at the right of the screen

- If your question was not answered or if you have any questions, please email us at mccop.info@nyu.edu

Thank You!

We thank you for participating in the webinar.

A recording of the webinar will be made available shortly.

Visit www.mc-cop.com for more information

Contact us at mccop.info@nyu.edu