Q&A for Integrated License Pilot Program,

Updated: November 17, 2014

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1. **What Rate Code should be used to submit claims for Primary Care Services?**

   The integrated pilot providers have been issued the following rate codes based on setting and "host" agency:

RATE CODE	RATE CODE DESCRIPTION	COS	SETTING
1480	OMH APG - ARTICLE 31 INTEGRATED SERVICES	0160	DTC
1483	OMH APG - ARTICLE 31 INTEGRATED SERVICES (SED)	0160	DTC
1486	OASAS APG - ARTICLE 32 INTEGRATED SERVICES	0160	DTC
1594	DOH OPD APG - INTEGRATED SERVICE	0287	HOSPITAL
1597	DOH DTC APG - INTEGRATED SERVICE	0160	DTC
1122	OMH APG - ARTICLE 31 INTEGRATED SERVICES	0287	HOSPITAL
1124	OMH APG - ARTICLE 31 INTEGRATED SERVICES (SED)	0287	HOSPITAL

   These rate codes should be used for all visits rendered at participating sites including those in which primary care is the only service rendered.

   Note, providers should not include system-generated rate codes (e.g., 1595, 1598, 1482, or 1485) on their claims.

2. **Is the integrated services rate the same amount as the one we are receiving for the OASAS service rate codes 4273-4275 (Hospital-based OASAS clinics not subsumed by APGs)**

   No, hospital based OASAS providers that have not converted to APGs will continue to bill using their current rate codes and continue to be paid the non-APG rate. However, when they convert to APGs (pending SPA approval) they will be able to submit Integrated Licensing claims retroactive to the DOS of the participating site's effective date and be paid at the APG Integrated Services rate.

3. **For patients who receive only Primary Care, how should providers submit claims to avoid denials due to timely filing? Will the delay reason code "03" suffice? Does the 90 day clock start from the date of the Notification Letter not yet issued to providers? Will the tentatively proposed date October 15th change to a later date?**

   For visits in which primary care is the only service provided during the visit the participating site will resubmit claims using the appropriate Integrated License rate code

(e.g., 1480, 1483, 1486, 1122, or 1124) retroactive to the participating site's effective date using delay reason code "03" which authorizes provider to bill for DOS up to two years retroactive from the claim submission date. Integrated License pilot providers will have up to 90 days from the participating site's effective date on their billing authorization letters to submit their retroactive claims. The date in which the 90 clock begins (yet to be determined) will be clearly stated on the final authorization letters.

4. **If the agency provided a "secondary" service (e.g., an OASAS service provided at the OMH-hosted pilot site) to a client at a pilot site on the same date and has NOT previously been paid for that secondary service, it can be added to the amended claim BEFORE it is submitted to eMedNY. Does this mean that for all the OMH services provided to patients, we should amend those claims and while doing so, add the primary care service to the Amended Claim?**

   All participating sites should submit claims that include all primary and "secondary" service(s) rendered on a DOS. If a provider submitted a claim using a non-integrated rate code (irrespective of whether they were paid for the claim) the provider should adjust the previously paid claim using an integrated rate code that includes all the primary and "secondary" service(s) rendered on a DOS. If a provider mistakenly submits a claim using an integrated rate code that excludes all the services rendered on a DOS the provider should submit an amended claim and be sure to include all the primary and "secondary" service(s). Please note, the state will not automatically reprocess Integrated License claims therefore providers will have to manually submit/resubmit these claims to paid.

5. **Should all claims that have been paid by Medicaid for services rendered in our Chemical Dependence Outpatient Program be voided and resubmitted even if we're using the same Rate Codes we used before being approved? Could the State issue retroactive adjustments for these claims since the Rate Code hasn't changed?**

   Hospital based OASAS clinics will continue to bill using their existing rate codes (e.g., 4273, 4274, 4275…). Upon CMS approval, these providers (including Integrated License Pilot facilities) will be issued separate billing instructions for claims reprocessing prior to converting to APGs.

6. **The "base rates" for the new integrated rate code(s) for the pilot facilities will be 5% higher than the current base rate(s) for each integrated clinic through SFY 2014/15, unless extended. Is the 5% already included in the rates issued to us by the State recently?**

The 5 percent enhancement has been added to the fee-for-service APG base rates for participating Integrated License sites based on NPI and zip code (effective through 3/31/2015).

7. **For a multiple service type visit in which 1 physical health and 1 mental service are rendered using the same procedure code should the second service be billed using the procedure modifier 59 on the second service?**

   Both services should be included on a single fee-for-service claim billed using the APG Integrated License rate code if the patient is an SSI recipient or Seriously Emotionally Disturbed child (receiving services at an eligible site). Alternatively, if the recipient is a not an SSI recipient the provider should include both services on a single claim and submit the claim to the mainstream managed care plan.

   Note, providers may use a modifier to indicate when a separate and distinct procedure is performed (e.g., Procedure Modifier 59) in accordance with the American Medical Association's approved coding/billing guidelines for the procedures/services coded supported by appropriate documentation that justifies the modifier selected.

8. **For a multiple service type visit in which 1 physical health and 2 mental health services are rendered should the second service be billed using the procedure modifier 59 on the second service?**

   All the services should be included on a single fee-for-service claim that will be billed using the APG Integrated License rate code for if the patient is an SSI recipient (Seriously Emotionally Disturbed child). The first paying mental health service will pay 100% and the second mental health service will pay 90%. Alternatively, if the recipient is a not an SSI recipient (SED child) the provider should include both services on a single claim and bill it to the mainstream managed care plan.

   Note, providers may use a modifier to indicate when a separate and distinct procedure is performed (e.g., Procedure Modifier 59) in accordance with the American Medical Association's approved coding/billing guidelines for the procedures/services coded supported by appropriate documentation that justifies the modifier selected.

9. **For a multiple service type visit in which 1 primary care service and 2 substance use disorder services are rendered how will the second SUD service be paid? Should a provider that bills for a managed care recipient bill the primary care service to the mainstream managed care plan and the SUD services FFS?**

All the services should be included on a single fee-for-service claim that will be billed using an APG Integrated License rate code. The first paying mental health service will pay at 100% and the second mental health service will pay at 90%.

10. **How will the APG Grouper Pricer discounting logic work for a multiple service visit in which 2 physical health and 1 mental health visit is rendered? How will the logic work for a multiple service type visit in which 2 physical health and 2 mental health services are rendered?**

    In the first case, the first physical health service will pay at 100%, the second physical health service will generally pay at 50% (except PT, OT, and speech therapy and unrelated ancillaries), and the mental health service will pay at 100%.

    In the second case, the first physical health service will pay at 100%, the second physical health service will generally pat at 50% (except PT, OT, and speech therapy and unrelated ancillaries), the first mental health service will pay at 100%, and the second mental health service will pay at 90%.

11. **Do the APG specific modifiers apply to this? (AG, AF, etc)? For services provided after hours, can the CPT Code be used to enhance reimbursement?**

    Yes, Integrated License providers that bill using APGs can use the modifiers listed on the APG website:
    http://www.health.ny.gov/health_care/medicaid/rates/methodology/modifiers_9-17-13.htm

    Also, pilot providers can use the after-hours procedure codes for services rendered outside of conventional hours of operation.

12. **When procedure(s) are provided to a patient and those service(s) are covered under the individual's Medicaid Managed Care Plan, the plan is financially responsible. Please clarify what is defined as a "Procedures" – I'm assuming these are services provided to patients that are in addition to the services authorized under Integrated Care. (Example: MRI; GI series; etc).**

    All the current Pilot providers are either "hosted" by OMH or OASAS which are only permitted to provide primary care services (e.g., General Practitioner, Internist, Family Practitioner, Pediatrician, or Obstetrician/ Gynecologist), behavioral health or SUD services depending on their license(s) held by the participating sites.

13. What are government rates and how do they impact the amount Medicaid Managed Care reimburses for services?

When procedure(s) are provided to a patient and those service(s) are covered under the individual's Medicaid Managed Care Plan, the plan is financially responsible. Participating providers should continue to bill plans for any in-plan services. Medicaid Managed Care Plans are currently obligated to pay the Medicaid FFS rates using APGs as the basis for payments for OASAS and OMH services delivered in OASAS, OMH and DOH licensed clinics through March 31, 2015 for Integrated License participating sites.

For, general managed care billing questions/concerns for mental health services:

http://www.omh.ny.gov/omhweb/clinic_restructuring/medicaid_managed_care/managed_care_QAs.pdf

Billing Instructions for Integrated Clinics

Please follow these instructions if you are a provider that bills Medicaid for services rendered at a certified integrated clinic. Note, this is a follow up to "Billing Guidelines for Integrated License Pilot Clinics" DOH/OMH/OASAS issued in July).

New APG rate codes have been developed for use by providers that have been certified as integrated clinics. In addition to mental health services, the integrated clinics will also be authorized to provide physical health ("DOH services") and substance use services (OASAS). The chart below indicates to which entity (a managed care plan or FFS Medicaid) a single service type claim should be submitted depending on the client's eligibility status. FFS claims are to be submitted using the new rate code and will pay a 5% payment enhancement, which will be available for FFS claims through DOS March 31, 2015.

ONE SERVICE TYPE PER VISIT

Claims billed for visits in which physical health services are the only procedures rendered should be billed to Medicaid Managed care. However, visits in which substance use services are the only procedures rendered should be billed FFS. Visits in which mental health services are the only procedures rendered should be billed FFS for SSI enrolled recipients and managed care for non-SSI recipients.

Billing Entity

	Service Type		
Eligibility Status	**OMH Services**	**Physical Health (DOH) Services**	**OASAS Services**
SSI *	Fee-for-Service	Medicaid Managed Care	Fee-for-Service
Non-SSI	Medicaid Managed Care	Medicaid Managed Care	Fee-for-Service

* Includes SED children that receive care at designated clinics.

MUTIPLE SERVICE TYPES PER VISIT

The only multiple service type visits that should be billed to managed care are ones comprising mental health and physical health services (see below) for non-SSI recipients.

Providers should utilize Delayed Reason Code "3" on their claims which will give facilities 90 days from the receipt of this notification to manually resubmit their claims retroactive to the site's approved billing start date. For multiple service type visits providers should combine all the procedures rendered on a single Date of Service at the participating "host" site which may require the provider to void/amend existing claims to obviate duplicate billing and ensure proper payment. Note, if you are an OMH-licensed "hosted" integrated clinic and have already submitted a claim for a dual eligible recipient in which the med max logic (i.e., "higher of" logic) was not applied, please resubmit your claim(s) to receive proper payment.

Billing Entity

	SSI	**Non-SSI**
Medicaid Managed Care	NA	Bill for a combination of MH and physical health services provided in a visit.
Fee-for-Service	Bill for any combination of two or more services including MH, OASAS and Physical Health services provided in a visit.	Bill for a combination of MH and OASAS services provided in a visit.