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)**
    - 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	APG	COMBINED WITH CPT	FULL WEIGHT APG AMOUNT	PCT APG WEIGHT	APG PAID	CAPITAL ADD ON	EXISTING OPERATING COMPONENT		
1	2	3	4	5	6	7	8		

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

10 — Rate Code

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
  - 837 Claims (Inst, Prof, Dental)
  - 270/271 Eligibility
  - 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?