December 3, 2013
OMH TCM to Health Home Claim Adjudication Process Webinar Q&A

Q1: What if we have nothing in the HH tracking system?

A1: You should first submit the crossover claim for your members as described in the reprocessing guidance as soon as possible so that you don't miss the two year timely filing window. Once those claims have been submitted, you must reach out to the Health Homes in your region and submit tracking system information **going back to your phase begin date** as soon as you can. The Tracking System **must** accurately reflect Health Home billing.

Q2: Does this information pertain to Phase 3 Counties? We started Health Home billing in April 2013 under the 185x and 138x codes.

A2: Yes, all 52xx claims outlined in the guidance, regardless of phase, will be reprocessed (this assumes that the Care Management Provider ID in the tracking system matches the Bill Provider ID on the 52xx claim). We've stressed that phase 1 providers have a very limited window for submitted 1/1/12 claims prior to the closing of the two year timely filing window. As a phase 3 provider, you are not under as much of a time crunch to submit the crossover month claim, but that does not mean that you should wait to complete this task.

Q3: We have been an active HH provider since 4/1/12. We have 66 Legacy clients that we have been paid for. Do I rebill for each month of legacy clients?

A3: No, you only have to submit a claim for the crossover month (see reprocessing guidance) for each member. DOH will reprocess all subsequent 52xx claims to the HH rate codes for your agency for members reported to the Health Home Tracking System.

Q4: Do we have to enroll in the health home any folks who received service between April 2012 and Feb 2013 even though they were terminated by the time we originally began billing health home services? (Phase 2 dates)

A4: Yes, all members that have been in your program since the beginning of your phase must be reported to the tracking system, even if they have since left your program.

Q5: When do Phase 2 members needs to submit crossover claims?

A5: Claims for the crossover month must be submitted as soon as possible. Claims must be submitted within two years of the DOS; claims submitted after the two year window are not accepted by eMedNY. For phase 2 providers, the crossover claims with date of services of 4/1/12 must be submitted by 3/31/14.

Q6: Is it all right to have two bills with the same date-- the first month for health homes and the last for ICM. For example for phase 2: is it all right to have an April 1 2012 DOS claim for health home services and an April 1 2012 (really March) for the TCM service?

A6: Yes. An edit was built into the system to allow for a 52xx and an 18xx/13xx claim for the same member with the same DOS during the crossover month only.

Q7: There is a specific amount of OMH legacy slots assigned to each of our entities; however the number of 52xx claims paid is in excess of these assignments. How will that affect us?

A7: To clarify, legacy slots are the maximum number of slots a provider was authorized to claim under the TCM program. The number of 52xx claims billed should never exceed the authorized maximum. The number of legacy slots for each provider was split into two amounts: the number that could be billed under the 185x rate codes and the number that could be billed under the 13xx rate codes. If a provider billed for the 52xx rate codes over their monthly cap for 185x rate codes, DOH will reprocess claims for members with the lowest acuity under the 185x rate codes and will reprocess any claims for the remaining members under the 13xx rate codes. After the OMH reprocessing is complete and the OMH TCM provider is aware that information reported to the Health Home Tracking System was inaccurate or incomplete, the OMH TCM provider is responsible for ensuring that the appropriate rate code is billed for any subsequent claim adjustments that are submitted by the OMH TCM provider.

Q8: Who voids the first month claim?

A8: You do not have to void the first month claim. You should submit a claim for the member with a DOS that matches the member's begin date in the Health Home tracking system. If the member has already disenrolled from your program and you have already billed for that member's last month of service under 52xx rate codes, you must void that last 52xx claim you submitted for that member.

Q9: When will we be able to make these adjustments?

A9: You can make these adjustments right now.

Q10: Should we include Medicare claims or members in this tracking sheet?

A10: Both straight Medicaid and Medicaid/Medicare dual eligible members should be submitted to the Health Home tracking system.

Q11: I'm in Phase 3 and have been billing the 18xx series since June 2013. Every month I bill with a date of the first for the month prior. Is this correct?

A11: No, in the Health Home program, the DOS on the claim must be the first date of the month during which the billable service was provided. For example, if a billable service was provided on July 7, 2013, the date of service on the Health Home claim would be 7/1/13.

Q12: If a discharged member falls within the crossover period and is not listed on the HH Tracking list, do we pick a HH enroll and include on tracking system?

A12: Yes. All members that have been in your program since the beginning of your phase must be assigned to a Health Home and reported to the Health Home tracking system, even if that member has since left your program.

Q13: We have never received a list! How can we receive one?

A13: The enrollment download file includes all members that have been reported to the Health Home Tracking System. If you have submitted information on members that have received care management services from your agency to the Health Home, the enrollment download provides you with documentation of the records that have been accepted to the Health Home Tracking System.