The New York State Office of Mental Health Adult Behavioral Health Medicaid Managed Care Billing Resource Guide

The New York State (NYS) Office of Mental Health (OMH) has compiled a list of common reasons for claims denials along with best practices and resources providers can use to ensure claims are submitted, processed and paid in a timely manner. Please note this guide is not in lieu of any other policy paper or billing manual.

Best Practices for Successful Provider Billing and Payment

Top Reasons for Claim Denials within Provider Control

1. ***Timely Filing***
   - In most cases, original claims must be submitted within 90 days from the date of service unless the provider gives the Medicaid Managed Care Organization (MMCO) valid documentation as to why it was delayed. Please refer to the provider handbook and/or your provider contract for MMCO-specific information.
2. ***Prior Authorization Required***
   - To avoid denials due to no prior authorization, providers should follow NYS prior authorization guidelines[1] and the NYS Health and Recovery Plan (HARP) and Mainstream Billing and Coding Manual.
   - Contact the MMCO's Provider Services Department when unsure if a service requires prior authorization. Find contact information for each MMCO in the Plan Matrix from the Managed Care Technical Assistance Center (MCTAC).
   - Ensure claim submissions include appropriate prior authorization numbers as needed.
3. ***Incorrect Rate/ Procedure Code Combinations***
   - Providers must submit correct rate and procedure code combinations. Refer to OMH/Office of Addiction Services and Supports (OASAS) posted rate codes and procedures (NYS Health and Recovery Plan (HARP) and Mainstream Billing and Coding Manual).
4. ***Duplicate Claims***
   - Reconcile provider agency records using the Electronic Health Record (EHR) to ensure claims already submitted are not resubmitted unless a correction is required.
   - For corrected claims, ensure the "Bill Type" Field (box #4 on the UB-04 claim form) accurately reflects that the submission is a corrected claim and not a new claim.
5. ***Bill Field Incomplete or Invalid***
   - Be sure to fill in the accurate code in "Bill Type" Field per CMS guidelines.
6. ***Disallow-Not Allowed Under Contract***
   - Make sure that all locations/services/programs are reflected in your contract.

[1] *Prior authorization guidelines and utilization management guidance can be found on the OMH Policy Guidance webpage*

Contracting

1. New York State law currently requires that MMCOs pay the equivalent of Ambulatory Patient Group (APG) rates for OMH licensed mental health clinics. MMCOs are required to pay 100% of the Medicaid fee-for-service (FFS) rate (aka, "government rates") for selected behavioral health procedures delivered to individuals enrolled in mainstream MMCOs, HARPs, and HIV Special Needs Plans (SNPs) when the service is provided by an OASAS and OMH licensed, certified, or designated program.
2. During the contracting process, providers should be aware of the following contractual protections contained in the Medicaid Model Contract:
    - Payment of Government Rates
        - Per Chapter 57 of the Laws of 2022, MMCOs must pay for Behavioral Health services at the applicable Medicaid/APG rates until at least March 2027, pending further extension.
    - Credentialing
        - MMCOs must accept OMH/OASAS licensure/certification and Adult Behavioral Health Home and Community Based Services (Adult BH HCBS) and Community Oriented Recovery and Empowerment (CORE) services designation in lieu of, not in addition to, the MMCOs normal credentialing process [MMC 21.4(a)(ii), 21.4(a)(iv)].
3. If providers are unable to sign a contract with an MMCO, single case agreements should be signed to maintain continuity of care for individuals and to encourage delivery of service or payment.
    - Single case agreements are also protected by the government rate mandate for ambulatory services.
    - Utilization management rules apply under a single case agreement.

Billing and Claims

1. Prompt Pay Law (DFS Prompt Pay Guidelines)- MMCOs must adjudicate clean claims within 30 days for electronic submission and 45 days for paper submission.
2. Review claims activity to ensure MMCOs are paying at the appropriate rates.
3. For UM authorizations, MMCOs and Providers must follow units as outlined by the OMH Coding Taxonomy. If provider is not submitting correctly, claims will be denied.
4. Authorization letter is NOT a guarantee of claims payment; ensure you follow listed coding guidelines.

Provider Appeals

1. Review contract with MMCOs for provider grievance, appeal and dispute resolution procedures.
2. Understand when to proceed with appeal or dispute resolution on a denied claim, rather than attempt to re-submit a denied claim.

OMH Provider Billing Call[2]:

- On the first Tuesday of September, December, March, and June from 1:00-2:00pm ET, OMH hosts a call with providers to discuss billing issues. MMCOs do not join this call.
- Please email OMH-Managed-Care@omh.ny.gov to be included on this call.

[2] *Billing questions and/or concerns should always be directed to the appropriate department within the MMCO first, as they are the payer in MMC and are responsible for providing technical assistance to providers. If after making a good- faith effort you are unable to resolve your issue with the MMCO directly, you may reach out to the State for assistance. Send questions and complaints to OMH-Managed-Care@omh.ny.gov using the OMH Question/Complaint intake form or NYSDOH.BCS.Behavioral.Health.Complaints@health.ny.gov*

Billing Resources for Adult Behavioral Health Medicaid Managed Care

OMH Managed Care Billing Page[3] and the OMH Managed Care Policy/Resource Page[4]

- BH Adult Billing and Coding Manual
- Coding Taxonomy
  - This file provides the required coding construct for billing the OMH/OASAS government rates for services.
- CPT Procedure Weight and Rate Schedule
- Claiming Guidance for Opioid Treatment Programs, ACT and PROS[1] (Unlicensed Practitioner ID Requirement)
- Part 599 Medicaid Billing and Fiscal Guidance Mental Health Outpatient Treatment and Rehabilitative Services
- CPEP Guidance for Managed Care (found under the OMH MMC Billing/Rates resources) | Supplemental Guidance
- Requirements of MMCOs to pay government rates:
  - Letter to Medicaid Managed Care Organizations
  - Reference Guide for Providers

Other Relevant Webpages:

- OMH Medicaid Reimbursement Rates
  - Approved Medicaid fee-for-service rates for all OMH programs.
- Part 599 Mental Health Outpatient Treatment and Rehabilitative Service (MHOTRS) Program
  - Outlines the requirements of the Clinic with regards to program and billing, applies to Medicaid FFS and Medicaid Managed Care.
- Part 599- Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) Program

Managed Care Technical Assistance Center (MCTAC):

- MCTAC Billing Tool
  - Interactive UB-04 claim form with information on completing all required fields. This tool may be used in conjunction with the OMH coding taxonomy, and other billing resources.
- MCTAC Revenue Code List
  - Identifies the revenue code the MMCO needs to accept, at minimum.
- MCTAC Managed Care Plan Matrix
  - MMCO specific billing information; includes contacts and billing manuals.

[1] Attending/referring billing guidance for MHOTRS services can be found in the Part 599 Medicaid Billing and Fiscal Guidance MHOTRS