

The New York State Office of Mental Health

Adult Behavioral Health Medicaid Managed Care Billing Resource Guide for Article 31 and Adult BH HCBS providers

The New York State (NYS) Office of Mental Health (OMH) has compiled a list of common reasons for claim denials along with best practices and resources providers can use to ensure claims to Medicaid Managed Care Organizations (MMCOs), Health and Recovery Plans (HARPs) and HIV Special Needs Plans (HIV-SNPs) 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**

- Medicaid Managed Care Organizations (MMCO) allow for at least 90 days to submit original claims from the date of service unless the provider gives the MMCO valid documentation as to why it was delayed. Please refer to the MMCO's 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 MMCO provider billing manual guidance.
- 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) at <https://matrix.ctacny.org/>.
- Ensure claim submissions include appropriate prior authorization numbers as needed.
- Utilize provider or member appeal process when there is disagreement with the reason for a denied authorization of a service. Use the MCTAC [Plan Matrix](#) to identify the appropriate Utilization Management contact for the Plan.

3. **Incorrect Rate/ Procedure Code Combinations**

- Providers must submit correct rate and procedure code combinations. Refer to OMH/Office of Alcoholism and Substance Abuse Services (OASAS) posted rate codes and procedures ([NYS Health and Recovery Plan \(HARP\) and Mainstream Billing and Coding Manual](#) and the [Coding Taxonomy](#)).

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 You can find these prior authorization guidelines and all other utilization management guidance at: <https://www.omh.ny.gov/omhweb/bho/policy-guidance.html#utilization>

Contracting

1. To ensure payment for services rendered, providers should contract with MMCOs for inclusion in Medicaid Managed Care Provider Networks. During this process, providers should ensure that all locations/services/programs are reflected in their contract.
2. During the contracting process, providers should be aware of the following contractual protections contained in the Medicaid Model Contract:
 - Payment of Government Rates
 - MMCOs must pay for Behavioral Health services at the applicable Medicaid/APG rates until at least March 2023 unless otherwise specified by NYS [\[MMC 10.21\(d\),10.23\(d\)\]](#). Amended January 2019 in the [NYS Budget](#).
 - Credentialing
 - MMCOs must accept OMH/OASAS licensure/ certification and Adult Behavioral Health Home and Community Based Services (Adult BH HCBS) 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 under the laws of government rates for ambulatory services.
 - Utilization management rules apply under a single case agreement.
 - Government rates mandate applies 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 or request an authorization to exceed those limits based on medical necessity. 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 managed care plans 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 Call²

- On the first Tuesday of every month from 1:00-2:00pm ET, OMH hosts a call with providers to discuss billing issues. Medicaid Managed Care Plans 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 managedcarecomplaint@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.
- [Upstate Adult BH HCBS Rates](#)
- [Downstate Adult BH HCBS Rates](#)
- [Adult BH HCBS Rate Increase Memo](#)
- [Claiming Guidance for Opioid Treatment Programs, ACT, PROS and Clinic](#) (Unlicensed Practitioner ID Requirement)
- [CEEP Guidance for Managed Care](#) (found under the OMH MMC Billing/Rates resources)
- [Government Rates Table](#) (updated monthly)
- Requirements of MMCOs to pay government rates:
 - [Letter to Medicaid Managed Care Organizations](#)
 - [Reference Guide for Providers](#)

Other Relevant Webpages:

- [OMH Medicaid Rates Page](#)
 - Lists all the government rates by specific service.
- [OMH Clinic Guidance](#)
 - Outlines the requirements of the Clinic with regards to program and billing, applies to Medicaid FFS and Medicaid Managed Care.
- [OMH Clinic Requirements under Managed Care](#)

Managed Care Technical Assistance Center (MCTAC): www.ctacny.org

- [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.

³ <https://www.omh.ny.gov/omhweb/bho/billing-services.html>

⁴ <https://www.omh.ny.gov/omhweb/bho/policy-guidance.html#billing>