



Health Home billing process

Medicaid Managed Care
(MMC)

July 2018

Agenda

- Introduction
- Overview
- Outreach process
- Enrollment
- Availity®
- Billing/claims procedures
- Feedback and Q&A

Overview

Pursuant to the changes imposed by New York State, effective July 1, 2018, the purpose of this overview is to:

- Discuss the procedures we have implemented to carry out the state's vision.
- Review outreach and enrollment parameters.
- Review the Health Home billing process to ensure accurate and timely claims submission, payment and remittance guidance.
- Answer any questions from the training.

Outreach process

- All outreach services effective on or after October 1, 2017, will not exceed two consecutive months whereas the second consecutive month must be a face-to-face service.
- Face-to-face contact is defined as an in-person meeting with the member and/or parent, guardian or legally authorized representative who has the authority to consent and enroll.
- Outreach billable months cannot exceed four months in a rolling 12-month period.
- Exception: Outreach services may exceed the limits cited above when actionable information from the managed care organization supports additional outreach.

Department of Health enrollment guidance

MMC billing and payment protocol for Health Home services

Only Health Homes that have been designated to serve children may bill Children's High, Medium and Low (HML) rates, as determined by the Child and Adolescent Needs and Strength-New York acuity algorithm, for members under age 21. A monthly *Children's Questionnaire* in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) must also be completed prior to submitting a children's Health Home care management claim.

Department of Health enrollment guidance (cont.)

MMC billing and payment protocol for Health Home services

Health Homes that are not designated to serve children (anyone under 21) must bill at the adult rate, which is determined using the MAPP HHTS HML clinical and functional assessment (formally known as *Adult HML Questionnaire*).

Department of Health enrollment guidance (cont.)

MMC billing and payment protocol for Health Home services

Any Health Home that serves a member who is 21 or over must bill the appropriate Adult HML Health Home rates. A monthly *Adult HML Questionnaire* that is similar to the *Children's Questionnaire* must be completed in the MAPP HHTS. This also applies to members 21 years and older who elect to be served by a Children's Health Home.

Getting started: register with Availity

Availity is the website for BlueCross BlueShield of Western New York (BlueCross BlueShield) where you will find information related to:

- Electronic data interchange (EDI) transmission procedures.
- *HIPAA*-compliant billing procedures.
- Claim submission guidance.

For questions about Availity, call Availity Client Services at **1-800-282-4548**, Monday through Friday from 8 a.m. to 7 p.m. ET (excluding holidays).

You can also select **Contact Support** under *Help* in the top navigation by accessing the website at <https://www.availity.com>.

Organization registration

Go to <https://www.availity.com> and select **Register** to begin this process.



AVAILITY PORTAL

LOGIN

REGISTER

Business Challenges Products Resources Vendors About Us 

Register for Portal Access

TECHNICAL SUPPORT

AVAILITY NETWORK STATUS

REGISTER

It's quick, easy, and free

The Availity Portal offers secure online access to multiple health plans and the ability to manage business transactions through a single, easy-to-use site. All you need is basic information about your business, including your federal tax ID.

FEATURES

REQUIREMENTS



PORTAL REGISTRATION

Let's get started!

Provider website: secure access only

- The Availity username and password are used for the BlueCross BlueShield and Availity secure provider self-service websites.
- The tools on the secure website (www.bcbswny.com/stateplans) let you perform key transactions.
- The website is also your source for informational notices, bulletins and updates that may affect the management of your practice and patients.

Help with Availity

How can I learn about payer specifics, additional tools, link-out options and more information?

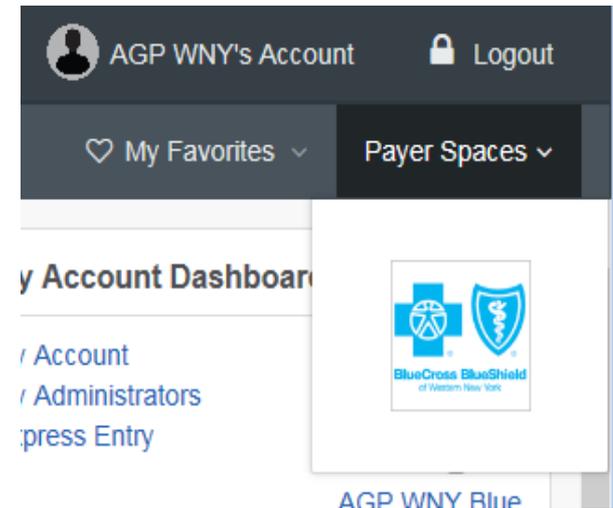
Don't be afraid to explore and use Availity Help. You can access help by:

- Selecting **Help | Find Help**. Availity Help will then display in a separate window or tab. Under *Contents*, select the topic you need.
- Selecting **Help | Get Trained**. The Availity Learning Center (ALC) Web Portal Products Learning Center will open in a separate window or tab.
- Selecting **Help | Contact Support** for options to contact Availity Client Services.

Payer Spaces and Provider Self Service

Navigate to *Payer Spaces* and select **Provider Self Service** to find information on all electronic transactions and claim billing:

- EDI registration information
- Electronic funds transfer (EFT) and electronic remittance advice (ERA) enrollment information
- Claims forms
- The provider manual (containing all billing policies and procedures)



Provider Self Service

Select the **Resources** tab then **Provider Self Service** to be redirected to the BlueCross BlueShield self-service site.

Home > BlueCross BlueShield of Western New York

 www.bcbswny.com



Applications Resources News and Announcements Sort by A-Z ▾

THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!

♡ BlueCross BlueShield of Western New York State Plans	07/19/2016
♡ Provider Self Service	07/28/2016

How to register for EDI

Access a *Trading Partner Agreement Form* at www.bcbswny.com/stateplans or by calling our EDI hotline at **1-800-470-9630**.

[Complete Trading Partner Agreement ▶](#)

HOME

▶ CLAIMS

Claims & Appeals

Forms

Electronic Data Interchange

Clear Claim Connection

Reimbursement Policies

Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) allows providers to submit claims, retrieve remittance advices and retrieve claim file acknowledgements from their computer system via modem and phone lines to the insurance carrier or clearinghouse.

Advantages for submitting claims electronically include:

- Electronic claims are not subject to postal delays.
- Claims may be transmitted 24 hours a day and seven days a week.
- Electronic claims are faster and more accurate.
- Electronic claims are acknowledged through notification and error reports, which are placed in your electronic mailbox.
- Electronic remittance advice is offered to all electronic submitters. This provides a cost savings and allows the provider to post payments automatically.

Contact Information

E-Solutions

Phone: (800) 470-9630

8:00 - 4:30 Local Time M-F

Email:

[e-solutions.support@amerigroup.com](mailto:solutions.support@amerigroup.com)



Resources

- [EDI Registration Form](#)
- [Remit Inquiry Information](#)

EDI

For payer IDs, please contact your clearinghouse.

Transaction companion documents (choose the applicable one) are also available on our website.



Companion Guides

-  [835 Health Care Claim Payment/Advice](#)
-  [837 Institutional Health Care Claim](#)
-  [837 Professional Health Care Claim](#)
-  [EDI User Guide for Nonemployer Group Trading Partners](#)
-  [276/277 Health Care Claim Status Request/Response — Real-time](#)
-  [270/271 Health Care Eligibility Benefit Inquiry and Response — Real-time](#)

EnrollHub: electronic payment enrollment

BlueCross BlueShield uses EnrollHub™, the secure Council for Affordable Quality Healthcare® solution, for EFT and ERA enrollment. EnrollHub is available at no cost to all health care providers.

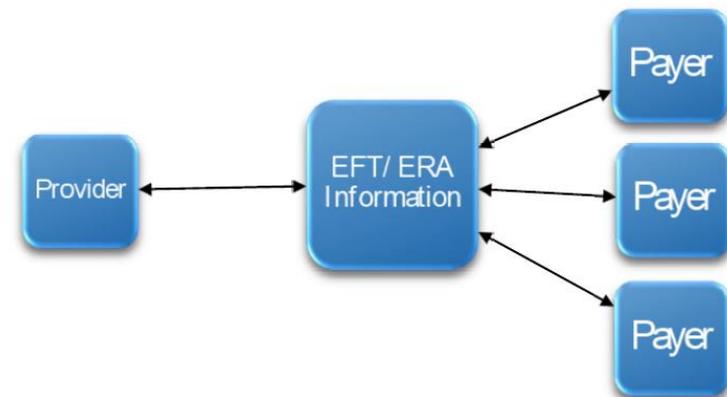
Visit www.caqh.org/eft_enrollment.php for more information and to create your secure account.

To learn more, call **1-844-815-9763**. Representatives are available Monday through Thursday from 7 a.m. to 9 p.m. ET and Friday from 7 a.m. to 7 p.m. ET.

Electronic payment and remittance services

Providers who enroll for electronic payment services:

- Receive ERAs and import the information directly into their patient management or patient accounting system.
- Route EFTs to the bank account of their choice.
- Can use the electronic files to create custom reports in their office.
- Can access reports 24/7.



How to submit claims

Providers can submit claims:

- On the Availity website (<https://www.availity.com>).
- Via *Batch 837* (electronic claims).
- Via Clearinghouse.
- On paper by mail.

For information on how to submit claims electronically, please visit our website at www.bcbswny.com/stateplans > Claims > Electronic Data Interchange.

Paper claim submission

Submit claims using the *UB-04 Claim Form* printed with dropout red ink or typed (not hand written) in large dark font. Mail to:

BlueCross BlueShield of Western New York
P.O. Box 62509
Virginia Beach, VA 23466-2509

Note: Modifiers approved by the American Medical Association and the Centers for Medicare & Medicaid Services must be used appropriately based upon the service and procedure.

Clean claim submission

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted timely.
- Is accurately completed with all required fields filled in per our billing guidelines.
- Is submitted on a *HIPAA*-compliant standard *UB-04 Claim Form* or the electronic equivalent of such claim form.
- Requires no further information, adjustment or alteration by provider or by a third party in order for us to process and pay it.

Billing guidelines can be found on our provider website. Navigate to Claims > Electronic Data Interchange > Companion Guides > 837 Institutional Claim.

UB-04 Claim Form

For a web-based interactive *UB-04 Claim* tool, view the Managed Care Technical Assistance Center (MCTAC) website at <https://billing.ctacny.org>. The billing tool is an interactive form that walks through the components required to submit a clean claim.

1		2		3a PAT. CNTL. # b. MED. REC. #		4 TYPE OF BILL													
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 THROUGH															
8 PATIENT NAME a				9 PATIENT ADDRESS a															
b		c		d		e													
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR. 14 TYPE 15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACCT 30 STATE		
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 OCCURRENCE DATE	OCCURRENCE SPAN FROM THROUGH		36 CODE	OCCURRENCE SPAN FROM THROUGH		37									
38				a		b		c		d		e		f		g			
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49					
PAGE OF				CREATION DATE				TOTALS											
50 PAYER NAME				51 HEALTH PLAN ID				52 REL. INFO		53 ASSO. BEN.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV. ID	
58 INSURED'S NAME				59 PREL.		60 INSURED'S UNIQUE ID		61 GROUP NAME				62 INSURANCE GROUP NO.							
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME											
66 DX		67 A		B		C		D		E		F		G		H		68	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73		74		75		76 ATTENDING NPI		QUAL			
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 OTHER PROCEDURE CODE		77 OTHER PROCEDURE CODE		78 OTHER PROCEDURE CODE		79 OTHER PROCEDURE CODE		80 OTHER PROCEDURE CODE		81 LAST		FIRST			
80 REMARKS		81CC a		b		c		d		82 LAST		FIRST		83 LAST		FIRST			
84		85		86		87		88		89		90		91		92			

Clear Claim Connection™

This tool on our website can help you determine whether procedure codes and modifiers will likely pay for your patient's diagnosis.

The screenshot shows the 'Clear Claim Connection' web application. At the top, there is a blue header with the title 'Clear Claim Connection™' and a red navigation bar with links for 'McKesson Edit Development', 'Glossary', 'About', 'Help', and 'Logoff'. Below the navigation bar, the main content area is light beige. It features a 'Gender:' section with radio buttons for 'Male' and 'Female'. Below that is a 'Date of Birth:' section with three input boxes for month, day, and year, followed by '(mm/dd/yyyy)'. A link 'Click Grid to enter information:' is positioned above a table. The table has columns for 'Procedure', 'Mod 1', 'Mod 2', 'Mod 3', 'Mod 4', and 'Date of Service'. The 'Date of Service' column contains checkmarks in the first four rows. Below the table is a link 'Add More Procedures>>'. At the bottom of the form are two buttons: 'Review Claim Audit Results' and 'Clear'.

Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Date of Service
					✓
					✓
					✓
					✓

Use Clear Claim Connection for guidance when you submit a claim. Submit payment disputes with a copy of the *Explanation of Payment (EOP)*, supporting documentation and a letter of explanation.

Submitting *HIPAA*-compliant codes

Use *HIPAA*-compliant codes from current versions of the following:

- Current Procedural Terminology (CPT)
- Health Care Common Procedural Coding System (HCPCS)
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
- Diagnosis-Related Group (DRG) codes
- Provider taxonomy codes

This applies to both electronic and paper claims. When billing codes are updated, you are required to use appropriate replacement codes for submitted claims. BlueCross BlueShield won't pay any claims submitted using noncompliant billing codes.

Health Home billing codes

Rate Code	Rate Code Description	COS	Provider Specialty Code	Rates Apply to	Revenue Code	Procedure Code	Procedure Code Description	Modifier
1862	Health Home Outreach (Adult)	15	371	Health Homes Serving Adults	0500	G9001	Coordinated care fee, initial rate	
1863	Health Home Outreach (Children)	15	371	Health Homes Serving Children	0500	G9001	Coordinated care fee, initial rate	U1
1864	Health Home Services - Children (Low)	15	371	Health Homes Serving Children	0500	T2022	Case Management, per month	U1
1865	Health Home Services - Children (Medium)	15	371	Health Homes Serving Children	0500	T2022	Case Management, per month	U2
1866	Health Home Services - Children (High)	15	371	Health Homes Serving Children	0500	T2022	Case Management, per month	U3
1869	Health Home Services - Children (Low) (Inc FFP)	15	371	Health Homes Serving Children	0500	T2022	Case Management, per month	U1
1870	Health Home Services - Children (Med) (Inc FFP)	15	371	Health Homes Serving Children	0500	T2022	Case Management, per month	U2
1871	Health Home Services - Children (High) (Inc FFP)	15	371	Health Homes Serving Children	0500	T2022	Case Management, per month	U3
1868	Health Home - CANS Assessment (Children)	15	371	Health Homes Serving Children	0500	G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management)	
1853	Health Home Plus/Care Management	15	371	Health Homes Serving Adults	0500	G9005	Coordinated care fee, risk adjusted maintenance	U4
1860	Health Home Services - Adult Home Transition	15	371	Health Homes Serving Adults	0500	G9005	Case Management, per month	U3
1861	Adult Home Assessment and Management Fee			Direct HH billing Through EMedNet				
1873	Health Home Care Management	15	371	Health Home Serving Adults	0500	G9005	Case Management, per month	U1
1874	Health Home High Risk/Need Care Management	15	371	Health Home Serving Adults	0500	G9005	Case Management, per month	U2

Billing type: 34
 Taxonomy: 251B00000x
 COS: 15

Rejected and denied claims

Find claims status information at <https://www.availity.com> or by calling Provider Services at **1-866-231-0847**.

There are two types of notices you may get in response to your claim submission:

- Rejected: does not enter the adjudication system due to missing or incorrect information
- Denied: goes through the adjudication process but is denied for payment

If you need to appeal a claim decision, please submit a copy of the *EOP*, letter of explanation and supporting documentation.

Routine claim inquiries

1500
HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

1. MEDICARE MEDICAID TRICARE CHAMPVA FECA OTHER
 (Medicare #) (Medicaid #) (Government's SSN) (Member ID#) (Health Plan ID# or ID) (SSN) (SSN) (ID#)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
 5. PATIENT'S ADDRESS (No., Street)
 6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other) (M/F)

7. INSURED'S ADDRESS (No., Street)
 8. PATIENT STATUS (Single, Married, Other) (M/F)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
 10. TO PATIENT'S CONDITION RELATED TO (Employer, Self, Other)
 11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Indicate the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the claimant, and suitable assignment below.)
 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of all benefits to the undersigned physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident or Pregnancy) (MM/DD/YY)
 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM/DD/YY)
 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM TO) (MM/DD/YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a) (17b) (NPI)
 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO) (MM/DD/YY)

19. RESERVED FOR LOCAL USE
 20. MEDICATED RE submission CODE (HEC, HO, etc.) ORIGINAL REF. NO.
 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3, or 4 to Item 21E by line)
 22. PRIOR AUTHORIZATION NUMBER

24. A.	B.	C.	D.	E.	F.	G.	H.	I.	J.
DATE(S) OF SERVICE	PLACE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	DIAGNOSIS (ICD-9-CM)	DIAGNOSIS (ICD-9-CM)	\$ CHARGES	Q. OF UNITS	R. UNIT PRICE	S. TOTAL	RENDERING PROVIDER ID #
MM DD YY	MM DD YY	BRNDS	EMG	MODIFIER	POINTER				
1									NPI
2									NPI
3									NPI
4									NPI
5									NPI
6									NPI

25. FEDERAL TAX ID NUMBER (SSN, EIN)
 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (YES/NO)
 28. TOTAL CHARGE (\$) 29. AMOUNT PAID (\$) 30. BALANCE DUE (\$)

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (if certify that the statements on the reverse apply to this bill and are made a part thereof.)
 32. SERVICE FACILITY LOCATION INFORMATION
 33. BILLING PROVIDER INFO & PH # ()

SIGNED: DATE: a. []/ []/ [] b. []/ []/ []

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Our Provider Experience Program ensures provider claim inquiries are handled efficiently and in a timely manner. Calls are handled by trained call agents in Provider Services. Call **1-866-231-0847**.

Complaints

Complaints, appeals and grievances should be mailed to:

BlueCross BlueShield of Western New York
Provider Complaint and Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

Claims adjudication

For claims payment to be considered, adhere to the process outlined below:

- Submit claims within 120 days from the date of service.
- Submit the claim within 120 days of receiving a response from the third-party payer (in the case of other insurance).
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 120 days from the date of eligibility and by the time we're notified of the eligibility/enrollment.
- Claims submitted after the 120-day filing deadline will be denied.
- Submit a corrected claim within the 90-day filing resubmission period.

Claims adjudication (cont.)

For claims payment to be considered, adhere to the process outlined below:

- We will provide a report to Health Homes to show payment breakdown by the care management agency.
- After filing a claim with us, review the weekly *EOP*. If the claim does not appear on an *EOP* within 30 business days of adjudication or you have no other written indication that the claim has been received, check the status of your claim on our website or by calling Provider Services at **1-866-231-0847**.

Payment disputes

Claim payment disputes must be filled within 45 calendar days of the adjudication date of the *EOP*. Forms for provider appeals are located on our website at www.bcbswny.com/stateplans.

You can submit claims in the following ways:

- Submit a written reconsideration request, including all necessary supporting documentation to:
 - BlueCross BlueShield of Western New York
 - Payment Dispute Unit
 - P.O. Box 61599
 - Virginia Beach, VA 23466-1599
- Call Provider Services to request a reconsideration at **1-866-231-0847**.
- Access and submit a reconsideration through the secure provider website at www.bcbswny.com/stateplans.

Key contact information

- Provider Services: **1-866-231-0847**
- Paper claims submission:
BlueCross BlueShield of Western New York
P.O. Box 62509
Virginia Beach, VA 23466-2509
- Website: www.bcbswny.com/stateplans

Key contact information (cont.)

BlueCross BlueShield network staff

Mary Ferber

Senior BH Network Relations Consultant

Phone: **1-716-796-2663**

Fax: **1-844-831-6603**

Mary.Ferber@Amerigroup.com

Kathy Leonard

Health Home Plan Manager

Phone: **1-716-796-2637**

Fax: **1-844-831-6603**

Kathleen.Leonard@Amerigroup.com

Next steps

- Register for Availity so you can access the secure BlueCross BlueShield provider website.
- Listen to a recorded Availity webinar at <https://www.availity.com>.
- Register for the EDI.
- Register for EFT/ERA services.
- Read your provider manual.
- Reference the *New York State Health Homes Provider Manuals* for specific program guidance at https://www.emedny.org/ProviderManuals/HealthHomes/PDFS/Health_Homes_Provider_Manual.pdf.

Resources

- Companion billing guides
- Orientation presentation
- Availability information
 - FAQ
 - Registration guide

Thank you

www.bcbswny.com/stateplans

Amerigroup Partnership Plan, LLC provides management services for BlueCross BlueShield of Western New York's managed Medicaid. A division of HealthNow New York Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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