Policy Title: Billing Requirements Policy

Policy Number: BCHN015

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Approved By: Miranda Blakeslee

Applicable to: Health Homes Serving Adults (HHSA)

Purpose: To provide clear guidelines for partnering Care Management Agencies (CMAs) regarding the standards for oversight, management, and accountability related to billing practices.

The establishment of these standards ensures compliance with all applicable program requirements and promotes consistency in service delivery and billing processes. Adherence to this policy supports the provision of high-quality member care by ensuring that services are delivered appropriately and that billing is accurate, complete, and submitted in a timely manner.

Contents

Definitions

Medicaid Analytics Performance Portal (MAPP)
Used to provide tools and program performance management technologies supporting care management efforts for the State's Health Home programs.

Health Home High, Medium, Low Billing for Adults (HML)
An assessment tool used to determine the monthly rate code under which to bill a member.

Electronic Medicaid of New York (eMedNY)
An access system that allows NY Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.

Electronic Provider Assisted Claim Entry System (ePaces)
A web-based program, developed by eMedNY on behalf of the NYS Department of Health, that allows enrolled New York Medicaid providers to submit and receive responses for HIPAA-compliant claims, eligibility requests, prior approval requests and claim status requests.

Fee-for-Service (FFS) Member
Members that do not belong to a Medicaid Managed Care Plan and receive services from providers who are contracted with the State based on an agreed upon rate for services.

Managed Care Organization/Plan (Plan)
A health maintenance organization/plan or prepaid health service plan, certified under the Public Health Law, that contracts with health care providers and medical facilities to provide care for members at reduced cost(s).

Policy

The Mary Imogene Bassett Hospital dba Bassett Community Health Navigation is a NYSDOH lead entity designated in Delaware, Otsego, Chenango, Schoharie, Broome, Oneida, Madison, Herkimer, Fulton, Montgomery, and Schenectady counties. The lead Health Home has the responsibility of billing all Health Home claims for Health Home service providers (CMA's). As such, the HH will submit all billing on behalf of our CMA's.

All Health Home services must be documented timely in the provided Care Management record system. CMA's should complete all billing assessments/questionnaires by the 3rd business day of the month following the end of the previous month, but no later than 60 days. Any claims submitted after 60 days may not be paid.

The HH will extract all billing information from the care management record system and submit claims on a weekly basis. Each CMA will be granted one account access to the billing portal as outlined in the Health Home Administrative Service Agreement. To ensure that CMA's are paid timely, the HH will process claims payments to CMA's, at minimum, on a monthly basis.

Procedure

Any billable service provided to or on behalf of an enrolled Health Home participant must include one of the five (5) core Health Home services as defined outlined in **BCHN001 – Core Billable Health Home Care Management Services**, ongoing and progressive engagement with the client must be documented in the care management record to demonstrate care planning and/or the client achieving their personal goals. Although periodic face-to-face

interaction with the Health Home enrollee is desirable, there is no face-to face contact requirement for adults (non-HH+ enrolled members) and care management activities can be conducted remotely if appropriate for the enrollee. See attached billing desk guide for specialty populations.

Requirements for Monthly Billing of Health Home Services

Medicaid Eligibility

In order to be able to bill for a member in a given month the following must be complete:

1. Member must be enrolled in the Health Home services.
2. Member must have active Medicaid. Medicaid must be confirmed active in the members chart each month prior to services being rendered. Medicaid confirmation is completed monthly using the Bassett Medicaid Check form available in the Care Management Record.
    a. If the provider does not verify eligibility prior to rendering services, the provider will be at risk for non-payment for services provided. For further information please refer to *Medicaid Restriction-Exemption Code Guide.*

High Medium Low (HML) Billing Questionnaire

All HML billing questionnaires must be answered accurately and with supporting documentation for the billing rate.

1. Must be answered as billable or non-billable.
2. The answers to these questions are critical and any questions that don't apply to a member or any questions that cannot be answered may be answered with Unknown.
3. If no questions are answered, or all are answered Unknown, the rate must be billed as Health Home Care Management.

Documentation Requirements

Documentation supporting billing must be present, updated, and finalized in the members care management record at the time of billing.

1. Eligibility Documentation including, but not limited to the Initial Appropriateness (IA), Verification of Diagnosis (VOD), etc.
2. Assessments including, but not limited to the Social Determinants of Health (SDOH), Comprehensive Assessment, etc.
3. Required Forms including but not limited to DOH-5055, DOH-5234, Communication Preferences, etc.
4. Signed, finalized, and up-to-date Plan of Care.
5. Core Health Home Service(s) were provided and documented in the Members Record as Billable Care Manager Note(s).
6. Upon request for disenrollment the Bassett Disenrollment summary, DOH 5235, Disenrollment Letter with attached resources should be completed in full, and uploaded to bill for the month of disenrollment.

High Medium Low (HML) Billing Questionnaire Question

HIV/AIDS Status

1. **Definition**
    a. CD4 (T-cells) testing is recommended at 12 weeks and every four months after initiation of ARV until CD4 is > 200 cells/mm3 on two measures.
    b. For those who are virally suppressed, CD4 testing is recommended at least every six months if CD4 is less than or equal to 300 cells/mm3.
    c. Every 12 months if CD4 >300 cells/mm3 and less than or equal to 500 cells/mm3.
    d. Optional if CD4 greater than 500 cells/mm3.
    e. Practitioners agree that a six-month period of more aggressive care management is appropriate for an HIV+ member with a medium or high range viral load, even though they should be tested again within that period.
        i. Quarterly for HIV+ persons with recent history of non-adherence, MH disorders, SU, poor social support, or other major medical conditions;
        ii. Every four months for most individuals after complete viral suppression;
        iii. Every six months for those with complete suppression for over one year and CD4 counts greater than 200 cells/mm3;
        iv. Note, when a person is failing viralogically, testing is recommended within four (4) weeks from a change in ARV, and at least every eight (8) weeks until completely suppressed.
2. **External Documentation** – Lab results, medical records, or documented conversation from collateral contact. For the purposes of this documentation a collateral contact must be documented as a service provider or managed care organization that can confirm lab results and/or have access to the individual's medical record.
3. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity, level of need, and billing category. Documentation would include progress notes and a care plan that reflects the intensity of services needed to address the category of billing claimed. The documentation of a care plan and progress notes would maintain billing for 90 days until external documentation is obtained.
    a. The goal is to secure needed community services including outpatient care, routine testing and illness self-management, food resources, etc. Objectives may include:
        i. Secure primary care physician (PCP) and/or specialty care, mental health or substance abuse services;
        ii. Secure transportation to/from appointments for behavioral and/or physical health appointments for assessment labs, etc.;
        iii. Reestablish benefits including Medicaid, public assistance; and,
        iv. Address homelessness by completing applications for housing such as HRA2010E, or secure shelter placement or other supportive housing intervention.

Homelessness

1. **Definition of Homelessness**
    a. **HUD Category 1** - An individual who lacks a fixed, regular, and adequate nighttime residence.

i. An individual who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; An individual or family living in a supervised publicly or privately-operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing); or
ii. An individual residing in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided.

b. **HUD Category 2** - An individual or family who will imminently lose their housing.
i. As evidenced by a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;
ii. Having a primary nighttime residence that is a room in a hotel or motel, and where they lack the resources necessary to reside there for more than 14 days, or credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days; and,
iii. Any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered; has no subsequent residence identified; and lacks the resources or support networks needed to obtain other permanent housing.

c. **Date Housed** – If Category 1 or Category 2 they will maintain that level of billing category for six months.

d. **If Category 1 or 2 and not housed**, they will maintain that level of billing category with appropriate observation documentation until housed or discharged from the program.

2. **External Documentation** - Letter from shelter or other homeless housing program, hospital discharge summary, eviction notice, documentation from local Homeless Management Information System (HMIS), or self-report.
3. **Observation** - Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the category of billing until external documentation is obtained.
a. The Goal is to find safe and stable housing. Objectives may include:
i. Submit applications;
ii. Landlord list;
iii. Re-establish benefits;
iv. Interventions would be evidence that more than routine care management services of a greater scope or frequency are necessary.

Incarceration

1. **Definition of Incarcerated** – Released from state prison or county jail after sentence is served. May be on probation or parole, but that is not required to meet the definition of incarceration. Incarceration would also include detention or arrest for

charges not adjudicated or sentenced; violations of probation/parole; released on bail awaiting arraignment; or other criminal justice status in which the person has an ongoing criminal justice issue requiring care management intervention.

2. **External Documentation** - Release papers; documentation from parole/probation; documented conversation from collateral contact; print-out from Webcrims or other criminal justice database; letter from halfway house; or self-report (for 90 days).

3. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the rate for 90 days until external documentation is obtained.
    a. The Goal is to secure needed community services including outpatient care, financial benefits, food resources, etc. Objectives may include:
        i. Secure primary care physician (PCP), mental health or substance abuse services;
        ii. Secure transportation to/from appointments for behavioral or physical health;
        iii. Reestablish benefits;
        iv. Reestablish housing.
    b. If a member is in AOT the current court order must be uploaded and all AOT requirements have been met.

Inpatient (IP) Stay for Physical Illness (PI)

1. **Definition of IP for PI**- Inpatient admission, regardless of duration, that would require significant care coordination post discharge. Significant will be defined as a member disengaged from care prior to hospitalization or the discharge plan requires linkage to care not currently established requiring additional care coordination needs such as arranging appointments, transportation, and follow-up testing.

2. **External Documentation**- Hospital discharge summary; documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date); print out from PSYCKES; RHIO alerts of inpatient admission or MCO confirmation of admission. Self-report does not meet criteria as sufficient documentation.

3. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the category of billing for 90 days until external documentation is obtained.

    a. The Goal is to secure needed community services including outpatient care, financial benefits, food resources, etc. Objectives may include:
        i. Secure PCP, mental health or substance abuse services, follow up appointments;

ii. Secure transportation to/from appointments for behavioral or physical health;
iii. Re-establish housing if in jeopardy or as part of discharge plan.

Inpatient (IP) Stay for Mental Illness (MI)

1. **Definition of IP Stay for MI** – Inpatient admission, regardless of duration, that would include CPEP under an observation status or other psychiatric emergency/respite programs. Inpatient admission for MI that includes a transfer to other units for complex needs, including physical health, would qualify as an inpatient stay for MI. For example, a member is admitted to a MH IP unit, then transferred to the medical floor, and discharged from a medical bed to community.

2. **External Documentation** -- Hospital discharge summary; documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date); documentation of Mobile crisis episodes; print out from PSYCKES; RHIO alerts of inpatient admission or MCO confirmation of admission; Self report does not meet criteria as sufficient documentation.

3. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the category of billing for 90 days until external documentation is obtained.
    a. The Goal is to secure needed community services including outpatient care, financial benefits, food resources, etc. Objectives may include:
        i. Secure PCP, mental health or substance abuse services, follow up appointments;
        ii. Secure transportation to/from appointments for behavioral or physical health;
        iii. Re-establish housing if in jeopardy or as part of discharge plan.

Inpatient (IP) Stay for Substance Use Disorder (SUD) Treatment

1. **Definition of IP Stay for SUD Disorder** – Inpatient admission in a hospital or community-based setting regardless of duration that could include detoxification services (medically managed, medically supervised or medically monitored, but not ambulatory detox), inpatient rehabilitation, residential stabilization and rehabilitation or other inpatient services as defined by OASAS.

2. **External Documentation** -- Hospital or provider discharge summary; documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date); print out from PSYCKES or MCO confirmation; and self-report.

3. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. For High category of billing, the documentation of care plan and progress

notes would maintain the category of billing for 90 days until external documentation is obtained.

a. Goal could be accessing community services, financial stability, developing safety plans, accessing higher levels of care, housing issues, food insecurity, access to medication, transportation, to attending medical or behavioral outpatient services.
b. Objectives must include:
    i. Secure primary care physician (PCP), mental health or substance abuse services, follow up appointments;
    ii. Reestablish housing if in jeopardy or as part of discharge plan.

Substance Use Disorder Active Use/Functional Impairment

1. **Definition of SUD Active Use/Functional Impairment** – Positive lab test for Opioids, Benzodiazepines, Cocaine, Amphetamines, or Barbiturates; OR care manager observation (with supervisor sign off) of continued use of drugs (including synthetic drugs) or alcohol with supervisor sign off ; OR MCO report of continued use of drugs or alcohol; AND demonstration of a functional impairment including continued inability to maintain gainful employment ; OR continued inability to achieve success in school OR documentation from family and/or criminal courts that indicates domestic violence and/or child welfare involvement with the last 120 days; OR documentation indicating Drug Court involvement AND the presence of six or more criterion of SUD under the DSM-5 which must also include pharmacological criteria of tolerance and/or withdrawal.

2. **External Documentation** - Based on assessment and information gathered by the care manager from substance use providers, probation/parole, and court ordered programs, domestic violence providers, local DSS, and other sources.

3. **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. For High category of billing, the documentation of care plan and progress notes would maintain the High category of billing for 90 or more days if, and only if, progress notes clearly document evidence of care management interventions to support SUD intervention. This includes motivational interviewing, education, referral and linkage to recovery coaching, and another peer supports. External documentation is preferred and every effort must be clearly documented, including specific efforts to engage the individual in harm reduction and safety planning.
    a. Goals related to barriers to attending medical or behavioral outpatient services, as a result of substance use; or evidence of motivational interviewing or stages of change related goals or objectives related to the attainment of vocational and educational goals.
        i. For example, goals and objectives might be utilizing motivational interviewing and stages of change approaches to move people towards active participation in treatment. In this case, a goal would be something like “I want my children back” in the person’s words.
        ii. The objectives would be to participate in programming or treatment and the interventions would be using these approaches to help the

person see how addressing their substance use issues might help them reach their goals.

Services Not Billable During Enrollment

The below services are not considered billable.

- Mailing a letter
- E-mailing an enrollee without receiving a response
- Texting an enrollee without receiving a response
- Receiving a piece of information from or regarding an enrollee. This includes letters, faxes, voicemails, and e-mails.
- Leaving a single voicemail for an enrollee, team member, practitioner, or practitioner's staff member.
- Any interaction with or on behalf of a member that does not provide one of the five (5) core Health Home services, regardless of mode of delivery, is not billable.

Timely Documentation

All activities will be documented in the Care Management Record:

1. All encounters billable or not billable will be recorded in the members records. The encounter must include a description of the activity/service provided, date of service and type of contact.
2. When a member has multiple encounters

All HML Billing Questionnaires are completed by the 3rd business day of the following month.

Billing Submission and Processing

Each month, the Health Home will process billing as follows:

1. The HH will review members being billed at a Health Home Plus rate, to ensure appropriate monthly billing.
2. Each month, HH enrolled members with a completed Initial/Annual Plan of Care (POC) in that month will be reviewed. This review will ensure requirements are met per policy.
    a. The HH will verify all POC signature regardless of type.
    b. The HH will verify reported POC dates present on the Netsmart "NYS Plan of Care Upload".
    c. The HH will import the file to MAPP-HHTS.
    d. The HH will then pull the Enrollment file in MAPP-HHTS to validate information was imported correctly.
3. Download the billing support file from Netsmart and upload to MAPP-HHTS by the 10th business day of the month for services provided the month prior.
4. Download the Billing Support File from MAPP-HHTS within 2 business days of processing the billing support file.
5. Review the Billing Support File to validate information sent to MAPP-HHTS.
    a. Errors unable to be corrected or mitigated by the HH will be sent to each CMA for review and correction.
    b. Each CMA will make necessary corrections as needed in Netsmart and notify the HH by email.
    c. The HH will update MAPP-HHTS to reflect corrected information for the final monthly billing submission.

    d. CMA billing contact and HH will communicate to resolve any questions or discrepancies regarding the billing roster.
    e. The HH will send the information reported on the Billing Support File to the appropriate CMA, at minimum bi-weekly.
6. Submit the downloaded MAPP-HHTS billing support download file to Millin Associates via Millin Portal.
7. Once available, the HH will generate and send a billing roster to each CMA via HCS that includes all paid claims for the month.
8. When the HH receives payment remits:
    a. eMedNY and MCO's will send Millin a Remit Advisory to be uploaded to the Millin Pro Application.
    b. Lead HH will check weekly if new remits have been loaded into the Millin Application.
        i. All claims submitted on behalf of the CMA will be viewable via the Millin Pro Provider Portal and associated to the CMA MMIS number.

Process for Overpayment

The Health Home will identify, report, and return all overpayments in compliance with applicable State and federal requirements. The organization will ensure timely action, accurate reporting, and implementation of corrective measures to prevent recurrence.

1. Overpayments may be identified through internal audits, routine monitoring, billing reviews, or external notifications. Upon identification, the Health Home will promptly assess and quantify the overpayment and determine the root cause.
2. The Health Home will document the nature of the overpayment, affected time period, methodology used to calculate the amount, and any contributing factors. All supporting documentation will be maintained in accordance with record retention requirements.
3. If the overpayment involves potential non-compliance or improper billing, the Health Home will follow the Department of Health self-disclosure process. A self-disclosure will be submitted that includes a description of the issue, the time period involved, the calculation methodology, total amount due, and corrective actions implemented.
4. The Health Home will report and return identified overpayments within 60 days of identification, or by the date any corresponding cost report is due, whichever is later. Repayment will be coordinated with the Department of Health or the appropriate Medicaid administrative entity.

Billing Blocks

There are timeframes per policy that Care Managers must meet in order to have claims processed and reimbursed. There are elements that must be present in a member's chart including:

1. Initial Appropriateness
    a. Segment begin date >= 6/1/2024
    b. Appropriateness criteria not submitted within 28 days of IA grace period
    c. Consent and Member Program Upload file is processed weekly. This ensures up-to-date information is maintained in the MAPP-HHTS.
2. Plan of Care (POC)
    a. Warning: Last billable service month before POC expires

        i. Member's POC previously submitted to the system on the POC Upload file expires the same month as the BI service date. Submit an updated POC to the system ASAP.
    b. Does not have Complete Plan of Care submitted within 56 days of Consent to Enroll.
        i. POC submitted on POC Upload file is expired as of BI service date, OR
        ii. POC not submitted on POC Upload within 56 days of EITHER consent to enroll or segment begin date (whichever is most recent).
3. Continued Eligibility Screening Tool (CEST)
    a. CEST outcome required after grace period
        i. the member's segment has passed the initial CEST grace period.
    b. CEST outcome expired for the Member
        i. the member's submitted CEST has expired.
    c. Warning: Last billable service date without CEST outcome.
        i. Member's submitted CEST Outcome expires the same month as the BI service date OR
        ii. No CEST Outcome has been submitted for member segment AND
            1. last month to bill w/o CEST outcome submission = BI service date
    d. CEST outcome required after the grace period
        i. For members enrolled in adult program (excluding HH+ and Adult Home members), no CEST submitted for member segment and BI service date is greater than or equal to the CEST Billing Block month as determined by segment begin date.
    e. Existing CEST outcome for the Member has expired
        i. For members enrolled in adult program (excluding HH+ and Adult Home members), submitted CEST outcome expired prior to the BI service date.

Additional Billing Requirements

The HH will be monitoring and tracking the CMA network to identify:

1. Maintenance of a 90% billing rate each month.
    a. Any CMA that falls below 90% for three consecutive months will be reviewed by the HH.
    b. The HH will conduct a meeting with a CMA to discuss barriers to billing and will determine a resolution.
        i. A review may result in a CMA being placed on a Performance Improvement Plan (PIP), based on historical patterns and reasons for not meeting billing expectations.

Training

All Health Home staff and contracted Health Home Service Providers (CMAs) involved in care management, documentation, billing, and compliance activities shall receive training on Health Home billing requirements, documentation standards, and overpayment reporting obligations.

Quality Monitoring

Routine Monitoring Activities

The Health Home will conduct regular monitoring of care management and billing activities, including but not limited to:

- Monthly review of billing submissions and rejection/error reports (e.g., MAPP-HHTS, eMedNY, MCO remittances)
- Review of documentation completeness and timeliness in the care management record system
- Validation of Medicaid eligibility and enrollment status prior to billing
- Review of HML Billing Questionnaire accuracy and supporting documentation
- Monitoring of non-billable activity compliance

Performance Monitoring

The Health Home will track provider performance indicators, including:

- Billing compliance rates (including adherence to the 90% monthly billing expectation where applicable)
- Timeliness of documentation and billing submissions
- Frequency and type of billing errors or rejected claims
- Compliance with Plan of Care and assessment requirements

Audit and Review Activities

The Health Home will conduct periodic internal audits of CMA billing and documentation practices. Audits may include targeted or random sample reviews and may be conducted more frequently based on risk, error trends, or compliance concerns.

Corrective Action

When deficiencies are identified, the Health Home will:

- Notify the CMA or responsible staff
- Require correction of identified errors within a specified timeframe
- Implement corrective action plans as needed
- Provide targeted retraining or technical assistance
- Escalate persistent non-compliance to formal Performance Improvement Plans (PIPs) or contractual remedies

Continuous Improvement

The Health Home will use monitoring results to identify systemic issues and implement process improvements to enhance accuracy, compliance, and overall program performance.

Supporting Policies and Resources

Bassett CHN Core Health Home Services and Care Management Policy
Bassett CHN Standards and Requirements of HH+ Member Service Provision
Medicaid Restriction-Exemption Code Guide
Billing Compliance Resource