NY Medicaid EPS

Billing Guide

Prepared for

myUnity Essentials Financial

Netsmart

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Table of Contents

Overview

Certified Home Health Agencies in New York State submit EPS Interim (optional) and Final (required) claims to NY Medicaid. Medicaid pays 50% of the total claim EPS amount when the Interim is submitted and 50% when the Final claim is submitted, or 100% on the Final if the Interim claim isn't sent.

The rate amount used for reimbursement calculation is based on the County in which the Agency is located. This information is stored in the Unit table in myUnity Essentials.

This guide explains the set-up and process needed to fulfil these billing requirements. For detailed billing instructions and regulatory compliance information, visit the New York Medicaid website:

https://www.health.ny.gov/facilities/long_term_care/reimbursement/episodic/eps_regional_wage_ind_factors.htm

https://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/

Setup

Rates & Weights

The standard rates and weights files along with CBSA wage index rates are loaded for your agency by Netsmart Support.

The standard rates can be viewed under **File > File Lists > PPS Rates** by setting the **Type** to **NY Caid**.

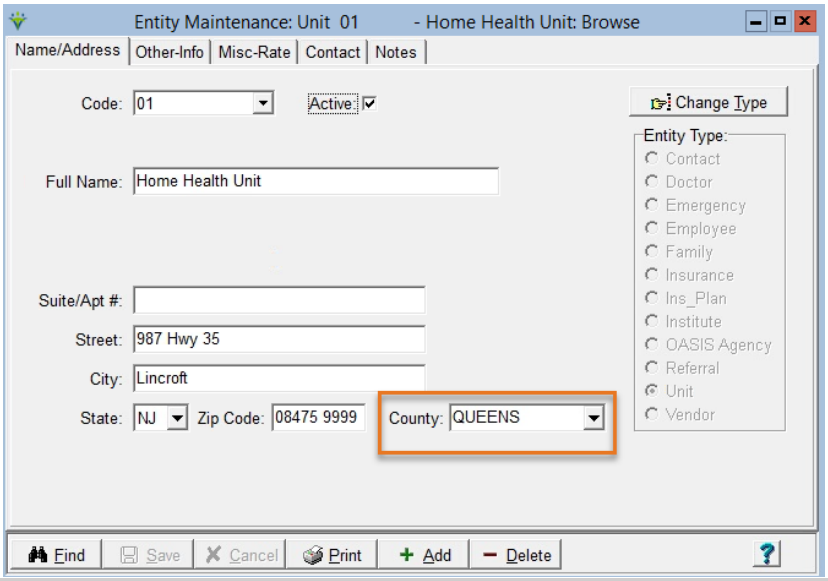
HIPPS Weights can be viewed under **File > File Lists > PPS Weights** by setting the **Type** to **NY Caid**

Unit Setup

Go to **File > File Maintenance > Entity**. Press **Change Type** and set the radio button to **Unit**.

Enter the **County**.

Contact Netsmart Support if Counties need to be added.

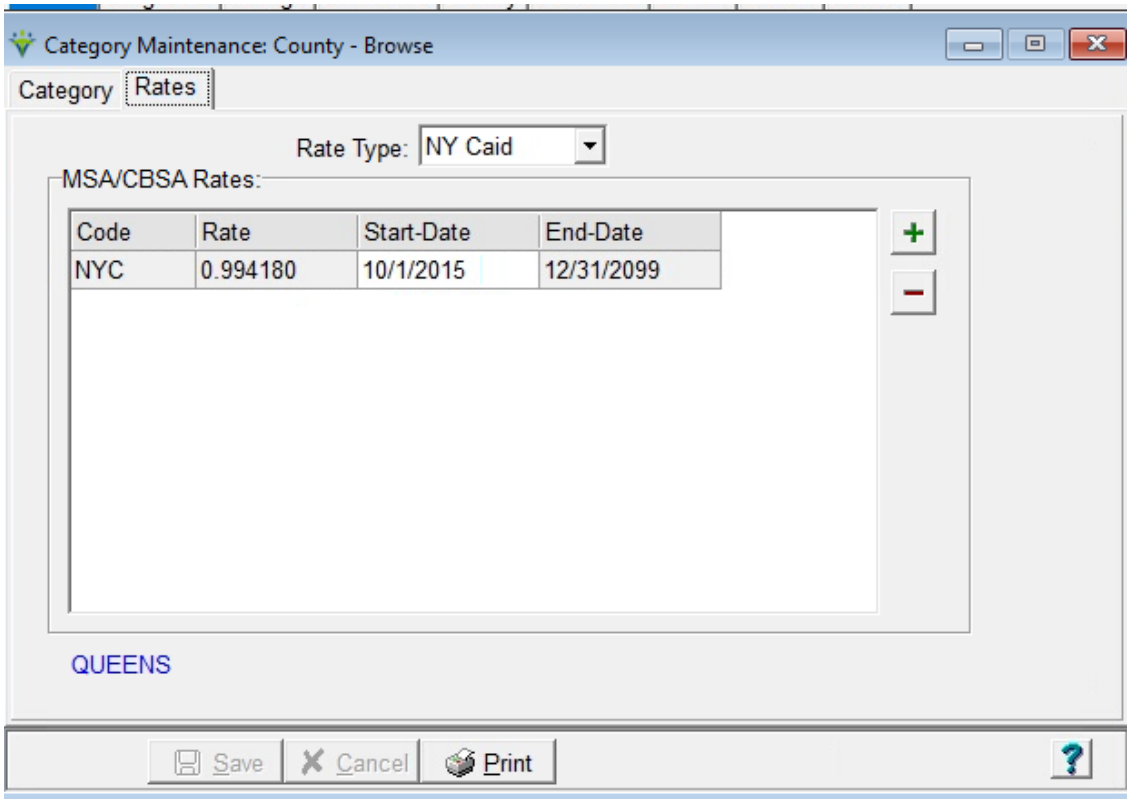


Add Rates to Counties

To review the setup, go to **File > File Maintenance > Category**, press **Change Type** and set the radio button to **County**.

Press **Find** to search for and select the county assigned to the unit(s).

Click on the **Rates** tab. Set the **Rate Type** to **NY Caid.**



Code:

NYC - counties located in the New York City region

NYS – this code is only used until 10/01/2022 for counties not in the NYC region

NSW – use this code with start date of 10/01/2022 for Nassau, Suffolk, and Westchester counties

ROS– use this code with start date of 10/01/2022 for counties that are not NYC or NSW

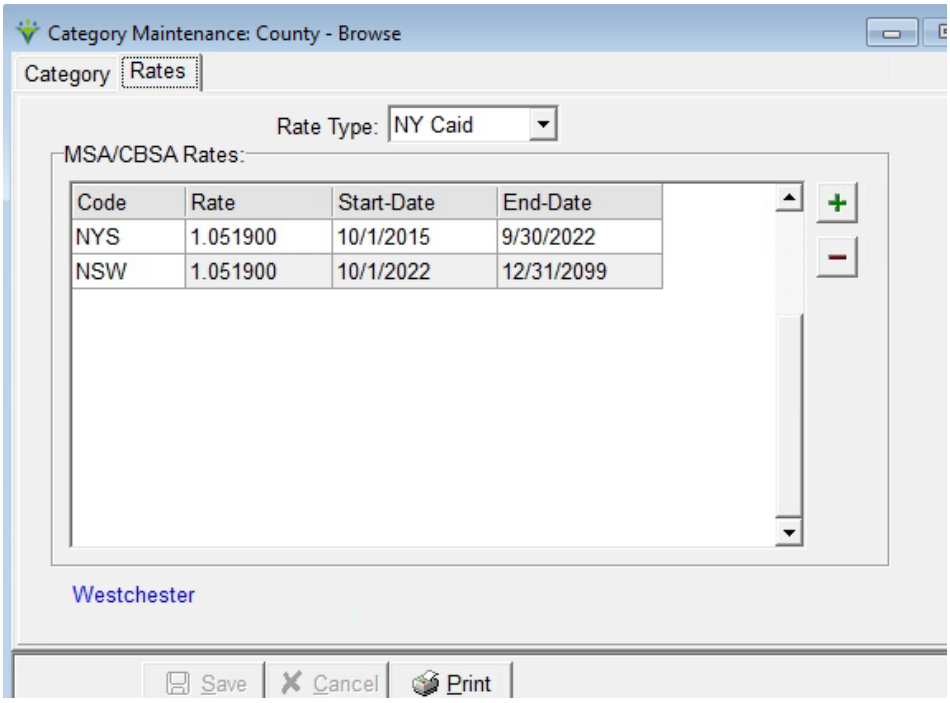
Rate: enter the NY Medicaid EPS Single Adjustment Factor supplied by NY Medicaid. A list of published rates can be found at:

https://www.health.ny.gov/facilities/long_term_care/reimbursement/episodic/eps_regional_wage_ind_factors.htm

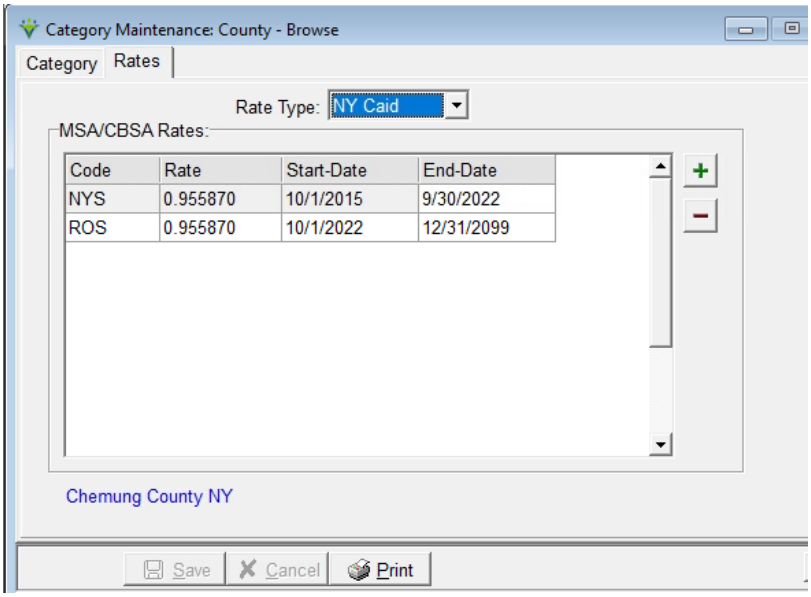
Start-Date/End-Date: enter the applicable effective dates. If end date unknown, enter the system default of 12/31/2099.

Repeat this step if your agency has multiple units with different counties.

Example of NSW county:



Example of ROS county:

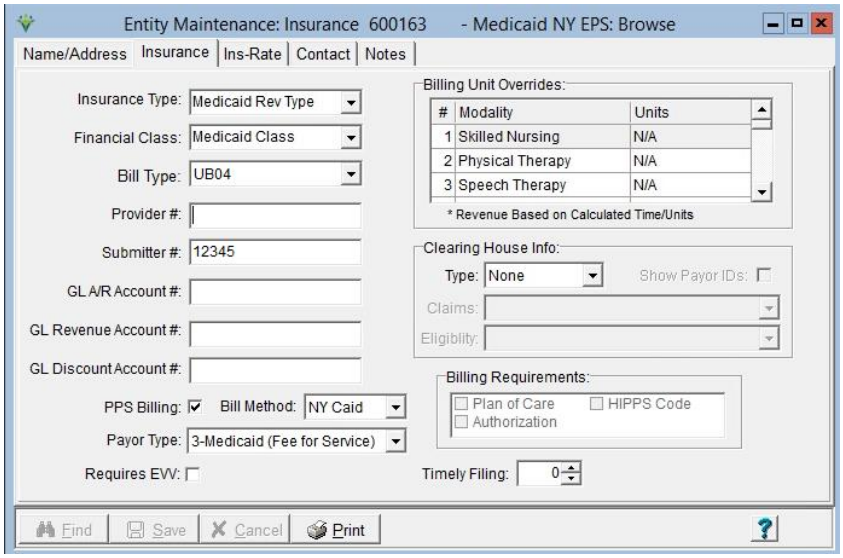


Insurance Setup

Go to **File > File Maintenance > Entity**, press **Change Type** and set the radio button to **Insurance**.

Press **Find** to search for and select the **NY Medicaid EPS insurance**.

Click on the **Insurance** tab and set the following:



Insurance Type: Medicaid Rev Type
Financial Class: Medicaid Class
Bill Type: UB04
Submitter #: enter the electronic claim payer ID for NY Medicaid EPS.
Enter **GL Account numbers** (optional).
PPS Billing: check this box
Bill Method: NY Caid
Payor Type: 3-Medicaid (Fee for Service)
Press **Save** when done.

Electronic Claim Option Set

Go to **Billing > Electronic Claims** and select the **NY Medicaid EPS** option set from the dropdown.

Contact Netsmart Support for assistance creating an Option Set if needed.

Press **Options** and set the following Locators:

0100.06 ISA*06 Interchange Sender ID: Enter 3-digit ID assigned by payer.
0100.08 ISA*08 Interchange Receiver ID: EMEDNYBAT
1000.33 NM1*40 03 Receiver Name: NYSDOH
1000.39 NM1*40 09 Insurance Receiver ID: 141797357
2010.90 REF*G2/LU Billing Provider Secondary ID: Constant Value, enter 003
2010.92 REF*G2/LU Billing Provider Secondary Qualifier: Constant (LU)
2300.05 CLM*05: 33S
2300.41 CL1*01 Institutional Claim Code: Constant Value, enter 9
2300.43 CL1*03 Patient Status: Default w/Discharge Reason Status Code Override
2300.50 REF*G1 Treatment Authorization Codes: Bypass
2300.53 REF*F8 Original Reference Code: Claim Reference Number (DCN#)
Note: This will pull the TCN assigned to the interim claim by Medicaid to the Final claim. The TCN is written to the interim claim's payment record via Electronic Remittance posting. This option can be set to Bypass if sending a Final Claim for a cert period that never had an Interim claim submitted.

2300.65 HI*BE Value Code Amount A: MSA/CBSA/Rate Code (+61 or 24) (PPS default), enter 24.
2300.73 HI*BH Occurrence Code/Date A: First Billable Visit or Assess Date for this Cert (PPS) and enter 50.
9000.30 Bill Processing Type: PPS

Save the option set changes and complete above steps for all additional Medicaid EPS option sets.

Hard Copy Claim Option Set

Go to **Billing > Printed Claims > UB04** and select the **NY Medicaid EPS** Option Set from the dropdown. Contact Netsmart Support for assistance creating an Option Set if needed.

Press **Options** and set the following Locators:

Box 31 Occurrence Code/Date: First Billable Visit Date or Assess Date for this Cert. Enter '50' for the Code
Box 39a Value Code Amount: MSA Code or Rate Code based on PPS Type.
Box 63 Treatment Authorization Codes: Bypass
PPS Processing Option: PPS

0FILL for Dual-Eligible Patients

2320.30 COB Loops – Choose Payment Amount is Constant Zero
2320.32 COB Insurance Sequence: Billed insurance is secondary
2320.33 COB SBR*09 Claim Indicator: Same as Default Except Payor Type 2 Gets Value 16
2320.34 COB CAS*01/02 Claim Adjustment Group/Reason: Bypass CAS Segment Entirely
2320.35 COB AMT*01 Prior Payment Type: Constant Value and enter A8
2330.20 COB DTP*03 Claim Adjudication Date: Bypass this Segment Entirely

Spenddown Set-Up

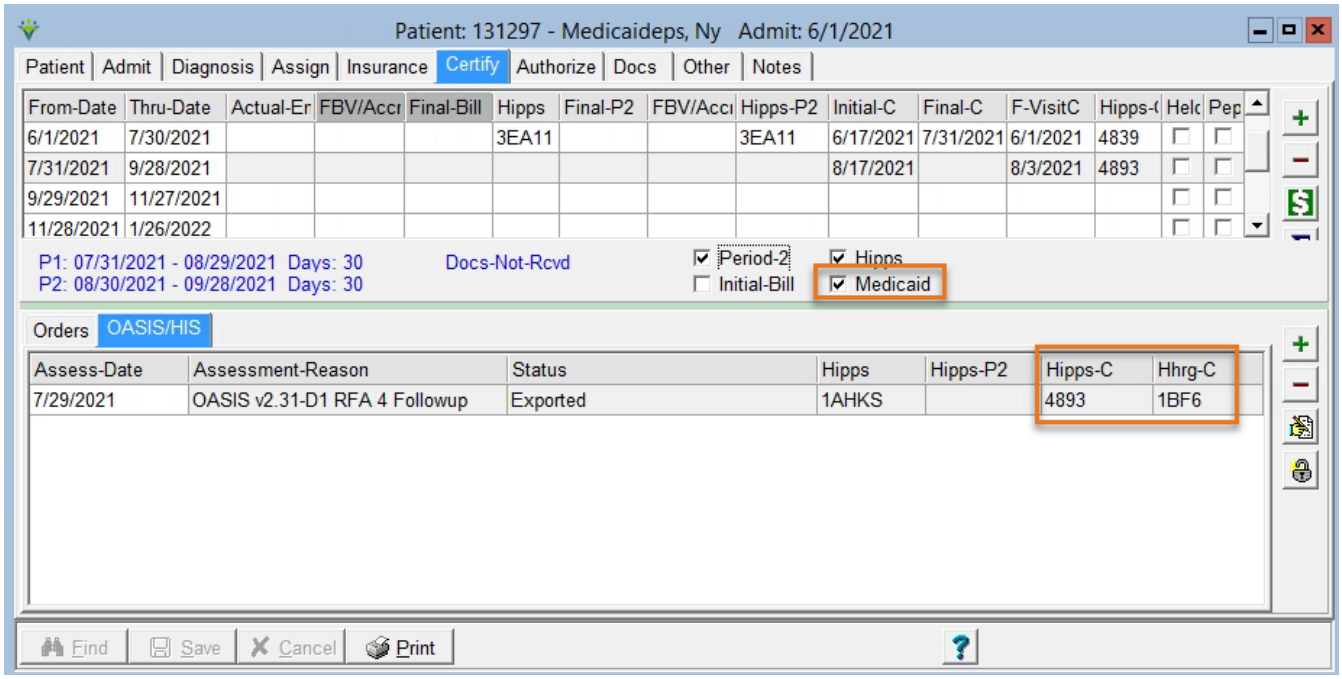
2300.66 HI*BE Value Code Amount B: Insurance Co-Pay Amount (Current Insurance) and enter 22.

Patient Information

Patients must have the NY Medicaid EPS insurance assigned and a locked OASIS assessment.

To confirm the Medicaid rate code is present, go to the **Patient > Certify** tab and choose the **OASIS/HIS** tab in lower half of screen.

Check the **Medicaid** option. The NY Medicaid rate and score will show in the **HIPPS-C** and **HHRG-C** fields:



Maternity Patients

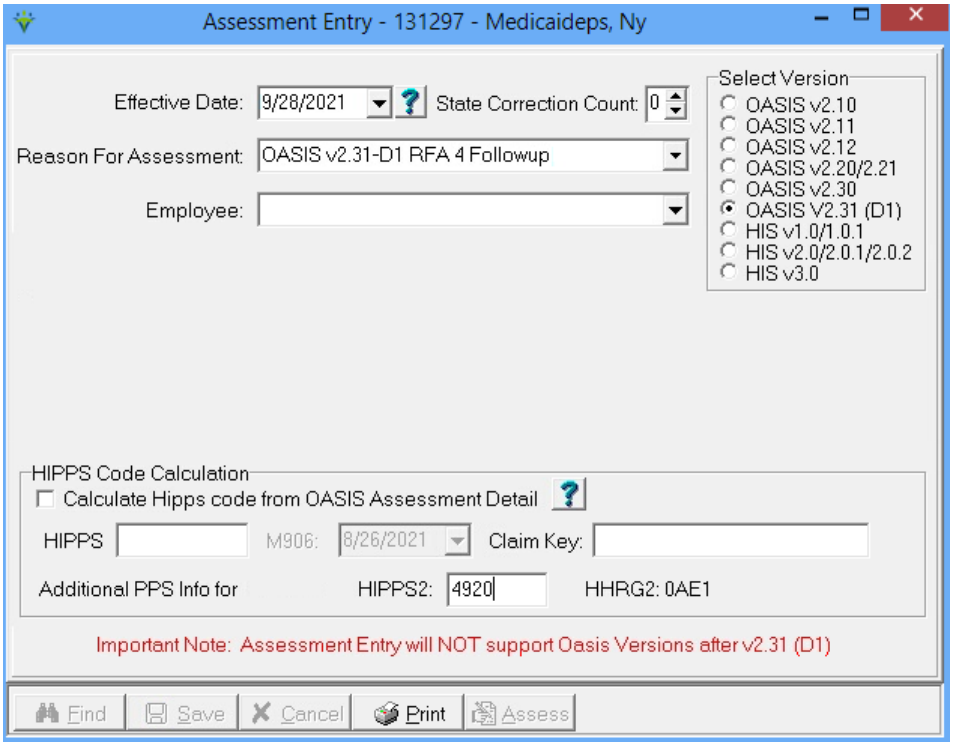
Go to the **Patient > Certify** tab and choose the **OASIS/HIS** tab in lower half of screen.

Press the **+** button to add a new row.

Enter the **Effective Date** of the OASIS record and the **Reason for Assessment**. Un-check **Calculate Hipps code from OASIS Assessment Detail**.

Enter **4920** in the **HIPPS2** field.

Save record.

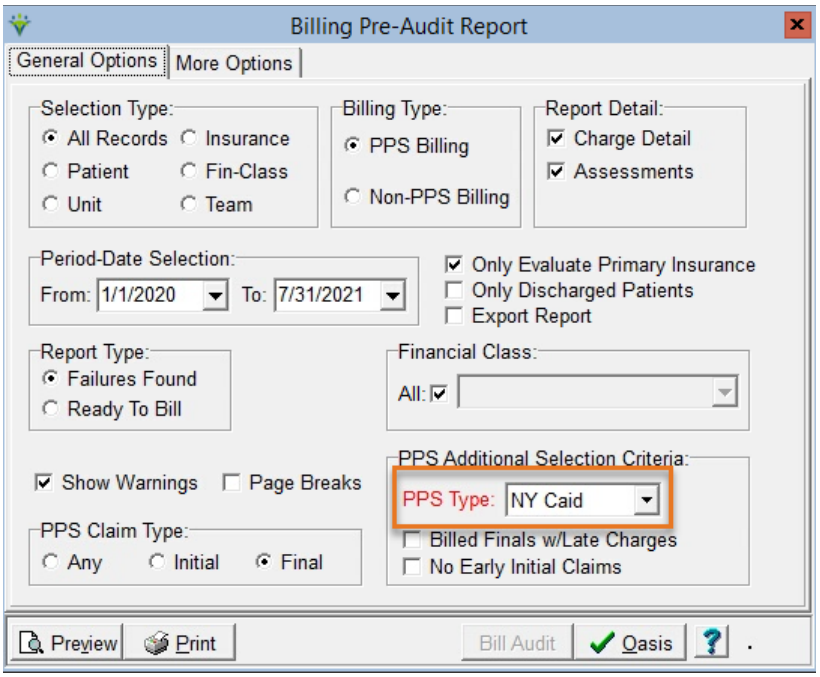


Billing Process

Billing Pre-Audit

This report is run to identify issues preventing claims from being billed to Medicaid or to view a list of Interims (Initial) and Finals that are ready to bill. Once all failures have been corrected you should get "No records found" when the report is run. You can then run it for Ready to Bill periods for Interims (Initial) or Finals.

It is recommended to occasionally run the report with **Billed Finals w/Late Charges** checked to capture any late visits that weren't billed on the original Final claim.



Billing Type: PPS Billing

Period-Date Selection: Enter date range for periods that need billing. Use a wide enough From date to capture any late periods needing to be billed.

Report Type: Failures Found or Ready to Bill.

PPS Claim Type: Select **Initial** if preparing to run RAPs or **Final** if preparing for final billing.

PPS Type: NY Caid (if doing Medicare PPS and NY Medicaid EPS billing, you may need to toggle this setting depending on which billing process is being run).

Run the report for Failures Found and use the Billing Pre-Audit Guide FAQ for detailed help resolving Failure messages.

Then run the report for Ready to Bill. Preview and jump to the last page of the report to populate the list of patients who are ready for a Billing Audit.

Close the preview window and press the **Bill Audit** button.

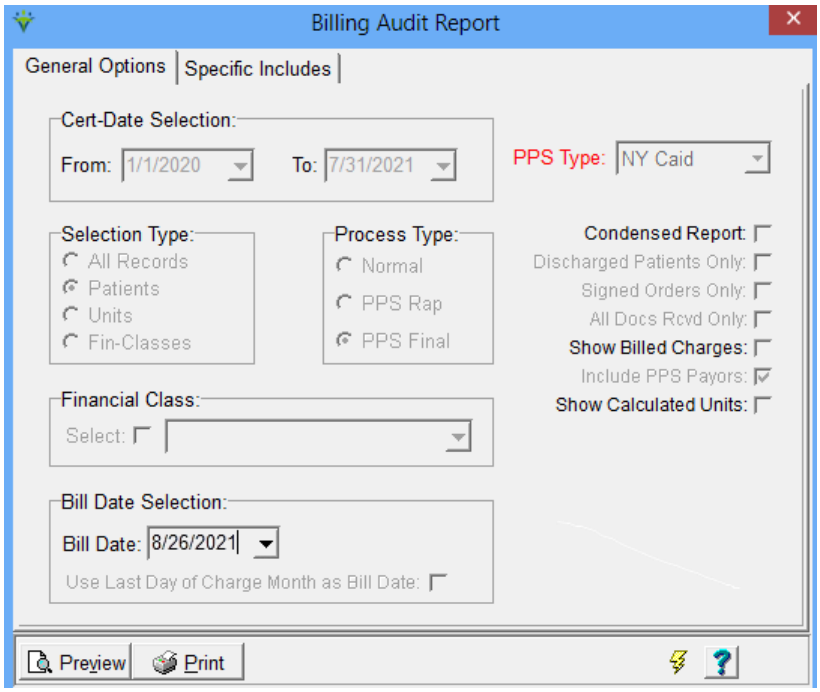
Billing Audit Report

Selections from the Pre-Audit flow to the Billing Audit Report.

Enter a **Bill Date** based on agency preferences. The Bill Date is the date used to age the receivable and is also used for claim generation.

Press **Preview.**

The interim (Rap) audit will include all charges entered/verified for the patient within the selected certification period.



Electronic Claim Creation

Go to **Billing > Electronic Claims**.

Report Sequence: Patient.

Selection Type: Set to Insurances and select the Medicaid EPS insurance on the Specific Includes tab. Press **Store** to save this selection for each time the option set is used. Alternatively, specific Patient(s) can be selected as well.

Submitted Type: Choose Un-Submitted Only to get new claims or All Records if you want to include previously submitted claims (All Records is typically used for resubmitting a claim).

PPS Claim Type: Choose “Initial” when creating an Interim/RAP claim file or “Final” when creating a file with final claims. It is not recommended to choose “All”.

Bill Date Selection: This date selection refers to the Bill Date chosen when posting the Bill Audit, NOT the period or charge dates. Example, a Final for a 01/01/2020 cert was posted on a Billing Audit with Bill Date 1/3/2020. In order to create a Final claim, enter 1/3/2020 as the date range.

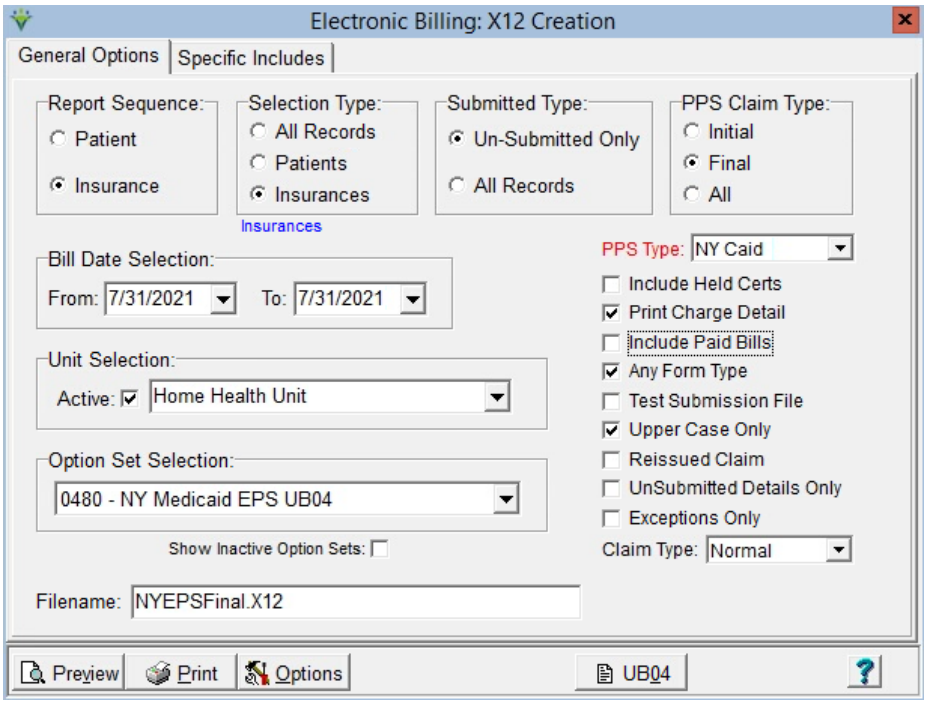
Unit Selection: Use this option to create a file for separate units. It is important to use this option if have different NPI #s set up for different units.

Option Set Selection: Choose your NY Medicaid EPS electronic option set. This should have been set up for you during the training or after confirming your agency had been approved for electronic submission and assigned a submitter ID from NY Medicaid. The same option set is used for creating both interim and final claims.

PPS Type: Select NY Caid.

Print Charge Detail: Check this box so you can confirm the correct Revenue/HCPCS codes are pulling to the claim file.

Filename: Enter the name for the submission file. A suggested naming convention is to use the date and type of claims. For example, use 01012020F.x12 for a Final claim file. Each file submitted should be given a unique name and saved in a local submission folder until final payment is received.



Press **Preview** when done making the selections. Any claims with exception messages on the report will NOT be pulled to the electronic file. Use the Electronic Claims Exception Guide for assistance resolving exception messages. Press **Preview** again, overwriting the filename if that file has not yet been transmitted. Close the preview window and **Mark as Submitted** if ready to transmit the file to the payer. Upload the file to the NY Medicaid website.

Note: If the agency has submitted an Interim claim for a patient's certification period, payments for that Interim (Initial) claim must be posted via Electronic Payments prior to creating its Final claim. If no Interim was submitted prior to sending the Final, Loop 2300.52 (TCN) should be bypassed in the option set.