

# NY Medicaid EPS

Billing Guide

*Prepared for*

**myUnity Essentials Financial**



**Netsmart**

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# Overview

Certified Home Health Agencies in New York State submit EPS Interim (optional) and Final (required) claims to NY Medicaid. 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/episodic/eps_regional_wage_ind_factors.htm)

[https://www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/chha/](https://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/)

# Setup

## Rates & Weights

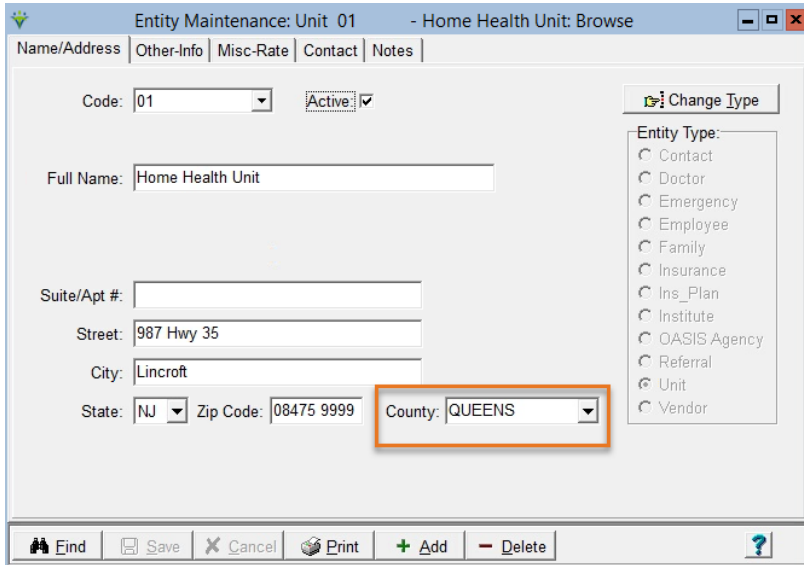
The standard rates and weights files along with CBSA wage index rates are loaded for your agency by Netsmart Support. The standard rates can be viewed under **File > File Lists > PPS Rates** by setting the **Type** to **NY Caid**. HIPPS Weights can be viewed under **File > File Lists > PPS Weights** by setting the **Type** to **NY Caid**

## System Settings

Go to **File > File Maintenance > System Settings** and enter your agency's **County**.

## Unit Setup

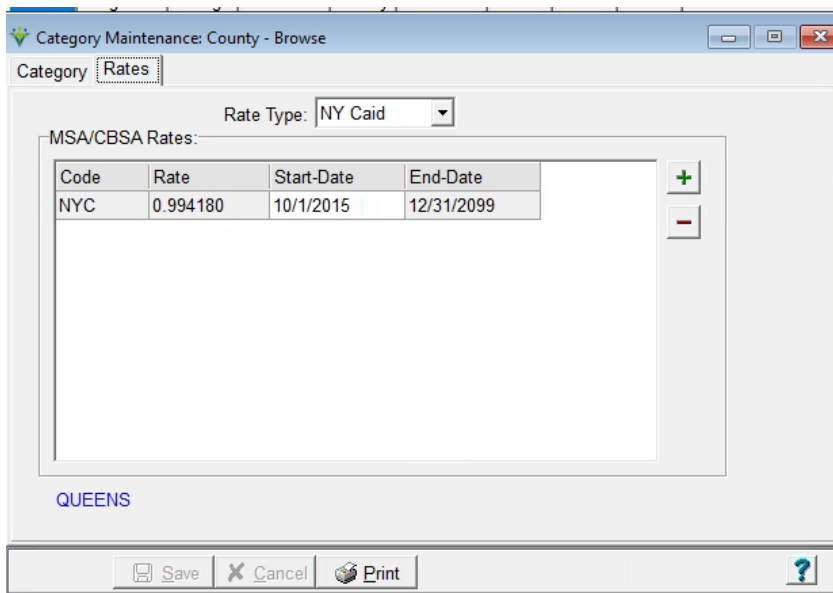
If your agency has locations in multiple counties enter a County for each Unit under **File > File Maintenance > Entity**. Press **Change Type** and set the radio button to **Unit**.



### Add Rates to Counties

Contact Netsmart Support if Counties need to be added. 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 a county and click on the **Rates** tab. Set the **Rate Type** to **NY Caidd**.



**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

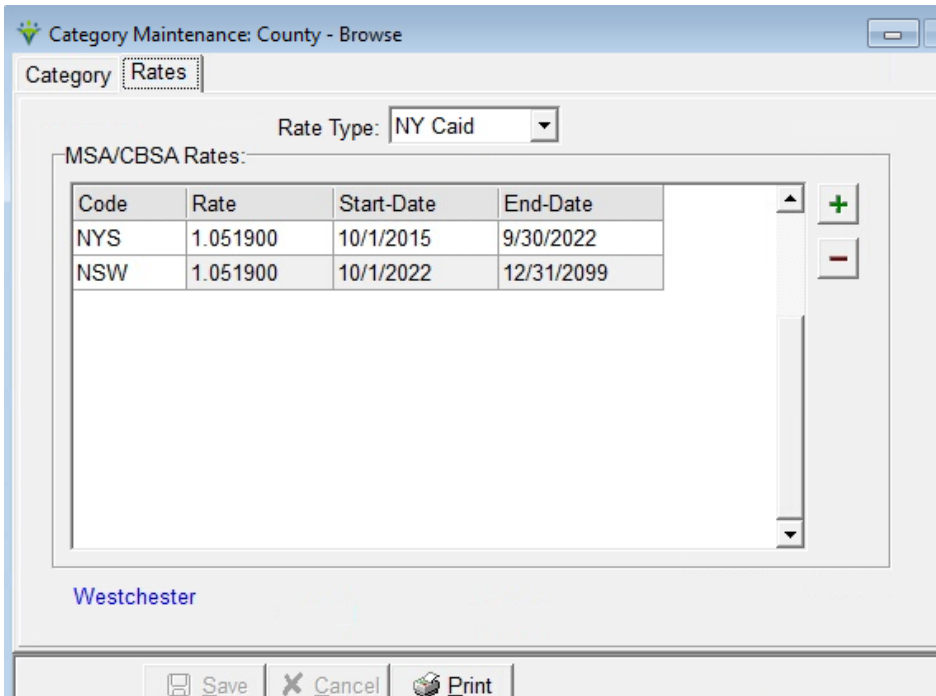
**Rate:** enter the NY Medicaid EPS Single Adjustment Factor supplied by NY Medicaid. A list of published rates can be found at:

[https://www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/episodic/eps\\_regional\\_wage\\_ind\\_factors.htm](https://www.health.ny.gov/facilities/long_term_care/reimbursement/episodic/eps_regional_wage_ind_factors.htm)

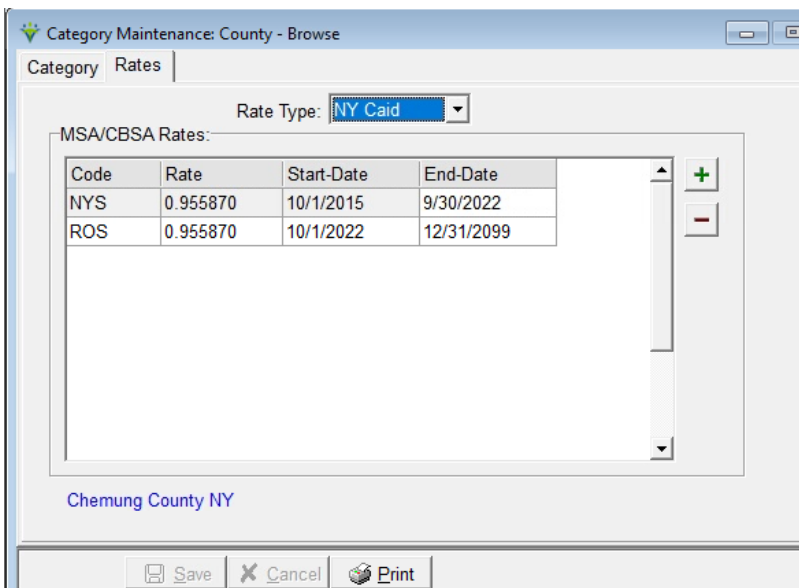
**Start-Date/End-Date:** enter the applicable effective dates. If end date unknown, enter the system default of 12/31/2099.

Repeat this step if your agency has office locations in multiple 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:

#	Modality	Units
1	Skilled Nursing	N/A
2	Physical Therapy	N/A
3	Speech Therapy	N/A

**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:

**ISA\*06 Interchange Sender ID:** Enter 3-digit ID assigned by payer.

**ISA\*08 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

**2300.52 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:

Patient: 131297 - Medicaideps, Ny Admit: 6/1/2021

From-Date Thru-Date Actual-Er FBV/Accr Final-Bill Hipps Final-P2 FBV/Accr Hipps-P2 Initial-C Final-C F-VisitC Hipps-4 Helc Pep

6/1/2021	7/30/2021				3EA11			3EA11	6/17/2021	7/31/2021	6/1/2021	4839	<input type="checkbox"/>	<input type="checkbox"/>
7/31/2021	9/28/2021								8/17/2021		8/3/2021	4893	<input type="checkbox"/>	<input type="checkbox"/>
9/29/2021	11/27/2021												<input type="checkbox"/>	<input type="checkbox"/>
11/28/2021	1/26/2022												<input type="checkbox"/>	<input type="checkbox"/>

P1: 07/31/2021 - 08/29/2021 Days: 30 Docs-Not-Rcvd  Period-2  Hipps  
 P2: 08/30/2021 - 09/28/2021 Days: 30  Initial-Bill  Medicaid

Orders OASIS/HIS

Assess-Date	Assessment-Reason	Status	Hipps	Hipps-P2	Hipps-C	Hhrg-C
7/29/2021	OASIS v2.31-D1 RFA 4 Followup	Exported	1AHKS		4893	1BF6

### 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.

Assessment Entry - 131297 - Medicaideps, Ny

Effective Date: 9/28/2021 State Correction Count: 0

Reason For Assessment: OASIS v2.31-D1 RFA 4 Followup

Employee: [Empty]

Select Version:  
 OASIS v2.10  
 OASIS v2.11  
 OASIS v2.12  
 OASIS v2.20/2.21  
 OASIS v2.30  
 OASIS v2.31 (D1)  
 HIS v1.0/1.0.1  
 HIS v2.0/2.0.1/2.0.2  
 HIS v3.0

HIPPS Code Calculation  
 Calculate Hipps code from OASIS Assessment Detail

HIPPS [Empty] M906: 8/26/2021 Claim Key: [Empty]

Additional PPS Info for HIPPS2: 4920 HHRG2: 0AE1

Important Note: Assessment Entry will NOT support Oasis Versions after v2.31 (D1)

# 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 Caidd (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 Caidd.

**Print Charge Detail:** Check this box so you can confirm the correct Revenue/HCPSC 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.