

CLAIMS AND BILLING

1. If a patient is dually eligible and a CHHA is billing for both Medicare and Medicaid services, the professional visits will most likely be billed to Medicare which would result in no professional visit for the Medicaid Claim. Will this be acceptable to only have Home Health Aide custodial services on a claim and would a full Medicaid payment result?

Yes. A Medicaid episodic claim with no professional visits is possible (as it is under the current FFS billing rules). Only those services which are properly eligible for Medicaid reimbursement may be listed on the Medicaid claim form.

2. Will Interim payment claims require a record 40 with 0023 revenue code and HIPPS code to indicate the billing record's first visit or SOC?

No. An interim payment (50%) is determined based on the values in Field 4 (Type of Bill) on the UB-04. The third digit in Field 4 must be "2" for an interim payment and "9" for a final claim.

3. Will Final Claims require the same matching revenue code and HIPPS code?

No. HIPPS codes should continue to be reported in accordance with existing UB-04 requirements. Revenue codes for services provided must be reported in accordance with the new matrix published by the Department. Accurate reporting of these codes and the corresponding number of service units for Medicaid covered services are a key component of the payment determination process. Thus, providers should ensure the revenue codes and corresponding service units are accurately reported on the claim.

4. Will there be an edit to match first visit to Start of Care for an initial episode?

For an initial episode, the date of the first Medicaid-eligible visit should be the same as the "Statement Covers Period From" date in field 6 of the UB-04.

5. How should services appear on the claim? All with a charge amount and zero reimbursement amount?

Underlying service units must be accurately reported in fields 42-46 of the UB-04. Although the total charges reported for such services will not be used in payment determination, providers should continue to report their usual and customary charges. The underlying services will be utilized, with statewide per unit prices determined and published by the Department, to calculate applicable LUPA or outlier payments. Providers will submit claims for episodic payments based on rate codes determined by the Department which correspond to the case mix that is generated by the Medicaid grouper from the information obtained from patient's OASIS assessments.

6. If final episode value is less than the interim payment (e.g., LUPA episodes), should claim amount be the anticipated takeback amount?

The final payment will be determined using the appropriate rate code and the underlying service units reported by revenue code. The final claim should have a claim number (TCN) that matches the interim claim. Based on this match, the interim payment will be voided and the final claim will be paid in full.

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

7. Medicare Final Claim payments are processed as a takeback of the Interim payment and then a total episode payment after the final claim has been submitted. Will Medicaid processing be the same?

Yes.

8. If the final claim results in a LUPA or PEP and the total episode value is less than the Interim payment, how will the payment appear?

This will be reported in the same manner as an adjusted claim under the present billing system, showing a "takeback" of the interim claim and full payment of the final claim. The final claim must have a claim number (TCN) that matches the interim claim.

9. If a PEP is identified after final claims remittance is processed how will adjustment to final claim payment be processed?

The provider is required to file a revised final claim, which will be considered an adjustment claim. The third digit of the Bill Type must be "9" and the TCN for the previous final claim should be reported. The adjustment claim will be paid in full and the original payment will be voided.

For episodic CHHA claims, the number "7" in the Bill Type will no longer be used to indicate an adjustment claim.

10. If additional services are billed after final claim is paid and the additional services result in an adjustment to final payment (outlier condition or changing a LUPA to a non LUPA) how will payment be adjusted? Would it be a takeback and new payment? Or just an additional payment?

Provider will file an adjusted final claim. The adjusted claim will be paid in full and the previous claim payment will be voided (shown as a takeback).

11. Should claims for non-episodic programs (LTHHCP, NFP, etc.) be submitted on a separate claim file than episodic claims? If so, will remittances be separated also?

Consistent with current fee-for-service billing rules, different programs must be billed on separate claims. Therefore, non-CHHA programs must continue to be billed on separate claims.

12. Would PERS (Personal Emergency Response System) and Telehealth be part of the episodic payment?

As an existing CHHA service, Telehealth is included in the episodic payment. PERS is not a CHHA covered service.

13. In regard to timely filing, would the requirement be to bill within 90 days of the start of the episode, the end of the episode, or specific to service dates?

Bills should be submitted within 90 days from the end of the episode.

14. How would DENIALS be handled for both visits as well as episodes?

Claims will be rejected if inaccurate information is transmitted. Billing edits are applicable to ensure that all underlying service units (e.g., visits, hours) are reported under proper revenue codes, and dates of service must be within the episodic service period. Edits are in place to ensure proper rate codes are utilized. For example, rate code age category will be edited against Medicaid system patient age as of the episode end date.

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

15. Is there a code similar to the OASIS matching key that is placed on Medicare claims? If not, then how would the scores that were used for the calculation be included on the bill?

There is no "matching key" like Medicare. Instead, a new occurrence code of 50 has been established on the UB-04 for assessment date, for tracking/audit purposes. The bill should be submitted with the rate code that corresponds to the case mix as determined by the Medicaid grouper which uses data from the patient's OASIS assessment.

16. How would the services provided to the patient (nursing visits, home health aide hours, etc.) be reported on the claim form?

The agency will report all Medicaid eligible services in UB-04 fields 42-46, using revenue codes provided by the Department. An interim claim must include at least one eligible service and the final claims should include all eligible services, including any listed on the interim claim.

17. What is the impact to secondary claims? Medicare/Medicaid dually eligible patients?

Medicare crossover claims will not be part of the episodic payment system, but will continue to be processed in the same manner as they were under the fee-for-service system. For dually eligible patients, maximizing third party liability coverage is still a necessary component of the Medicaid billing system. Only services determined and verifiable by the agency as eligible for Medicaid (and not otherwise covered) can be included on an episodic claim.

18. Explain how the calculated classification code will look; and how is it represented on the claim?

Rate codes will be utilized to bill for payment. These rate codes will correspond to the patient case mix as determined by the Medicaid grouper which uses data from the patient's OASIS assessment.

19. Will the services require authorization and would the authorization number be required on the claim?

Service authorization requirements will be consistent with existing requirements (e.g., physician order, medical record, etc.)

20. When will the 5010 companion guide that reflects changes due to the PPS Reimbursement model be published?

There will be no updates to the 5010 companion guide. Detailed billing guidelines will be published by the Department.

21. Are Interim and Final payments equal for all episodes? 50/50? Would it be different for the first billing cycle, compared to subsequent billing cycles?

Interim payments for all episodes are calculated as 50% of the total episodic rate, assuming no adjustment for LUPA, PEP, or outliers. Final payments are 100% of the actual amount due.

22. Is the rate code based on the patient's age at the beginning of the episode, start of care, or the end of the billing episode?

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

The billed rate code must be consistent with the patient's age as of the "Through" date on the claim. In some cases, this will require using a different rate code on the interim and final claims.

23. Is a 329 claim considered an adjustment claim?

Only if it includes the TCN of the claim being adjusted.

24. If the TCN number from the Interim payment is reported on the final claim, what field on the UB04 is it reported in, and what segment in the 837I?

For 837I, the TCN is reported in the REF02 segment of the 2300 loop, with an F8 qualifier in the REF01 segment. For UB04, Form locator 64, data element is "Document Control Number (DCN)."

25. If a claim is filed which covers parts of three calendar months, and the patient lacked eligibility during one of those months, will the entire claim be denied, or will partial reimbursement occur?

The entire claim will be denied.

26. When we submit an Interim Claim, coverage is established for that month, but when we bill final payment 2 months later, if there is no coverage is the final payment pended?

Yes. Final claim will be pended for Edit 00162 (RECIPIENT INELIGIBLE ON SERVICE DATE).

27. What occurs if an interim payment is made but a final claim is not submitted by the provider?

The interim payment is voided 120 days after the original adjudication date (on remittance advice) if a final claim with the TCN of the interim claim is not received. (This will be increased to 150 days after April 1, 2012).

28. Rate Codes are reported in fields 39-41 - is there a revenue code for the rate code? Should there be a price attached to the rate code? If so, would this be the 50%?

Rate codes should be entered in the same method used with fee for service claims. There is no price-specific information entered with a rate code on a claim.

29. Will there be changes to the Epaces system (screens/entering claims/adjustments)?

There will be no changes to ePACES as a result of the Episodic Payment System. Providers who need guidance on using ePACES to submit episodic claims should contact Computer Sciences Corp. at 800-343-9000.

30. If the episodic rates change in the middle of the episode, will reimbursement be based on the rates in effect at the beginning or end of the episode?

Rates in effect at the beginning of the episode will apply.

31. Are non-covered charges to be reported on the final claim?

Non-covered charges may be reported at the discretion of the provider. They will have no impact on the claim payment amount.

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

32. When billing Medicare the rate code takes on the first visit date - is this true for NYS Medicaid or does the rate code not have a date?

There is no date directly associated with the rate code.

33. Our Home Health staff does Maternal Child Health visits - would these visits also have to be episodic billing?

If the patient listed on the claim is 18 or older, episodic billing will be required. However, because federal regulations do not require an OASIS assessment for maternity patients, a special rate code (4920) has been created for maternity patients for whom no OASIS has been completed. Rate code 4920 will have the same Case Mix Index and Outlier Threshold as the lowest acuity group in the 108 OASIS-based rate codes (4810).

For all other episodic billing rate codes, the Medicaid claim form must include Occurrence Code 50 and this code must be used to report the most recent assessment date prior to, or coincident with, the start date of the episode. Occurrence Code 50 will not be required for Rate Code 4920, which can be used only for maternity patients.

Providers may, at their discretion, complete an OASIS assessment for a maternity patient and use a different rate code as applicable.

Consistent with federal rules, maternity patients are defined as: patients who are currently or were recently pregnant and are receiving treatment as a direct result of such pregnancy.

34. In field 46 on the UB-04 should the service units be reported as visits, hours, etc.?

Please refer to the "Billing Guidelines" document.

35. If a patient is not eligible for Medicaid at the beginning of an episode that is already being billed to Medicare, but becomes eligible for Medicaid after the start of the episode, how is payment processed?

The Medicaid episode cannot start until the patient is eligible for Medicaid and a Medicaid eligible service is provided.

36. In the event the patient is discharged prior to the end of an episode and the episode is going to be PEPPED, and if the discharge occurs prior to the patient's DOB, then will DOH adjust the rate accordingly?

It is the provider's responsibility to assure that the billed rate code is consistent with the patient's age on the end date of the episode (the "through" date on the claim).

37. If a Medicaid episode is started due to a billable visit being in the agency's system, and after creating the episode and billing, a visit prior to the episode start date is released from suspense or appears due to late visit entry, can agencies void the original episode and start anew with the new first billable visit?

The provider has the ability to submit an adjusted interim claim and an adjusted final claim, as well as the ability to void a prior claim. The new submitted claim would reflect the corrected dates.

38. If there are assessment response changes after the Interim Claim is submitted and the Final Claim has a different CMG code, will this be accepted by Medicaid? Which group will be paid for the final payment, the first one submitted or the one on the final claim?

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

There is no requirement that the Interim Claim and Final Claim have the same rate code. The billed rate code must be based on an OASIS assessment which occurs on or before the start date of the episode, but not more than 60 days prior to the start date.

39. Does the EPS have the concept of a 'Known LUPA' or 'No RAP LUPA'? That is, episodes the agency knows will be a LUPA are billed using a Final Claim only, no RAP submitted.

The provider is not required to submit an Interim claim. If the Final Claim does not match up with an Interim Claim, the entire Final Claim will be paid (if approved for payment by eMedNY).

40. How should supplies be reported or entered within the NY EPS claim?

There will be no change in Medicaid policy regarding supplies which may be billed by a CHHA. Supplies must be billed on a separate claim, not on the episodic claim.

41. For dually eligible cases where Medicare is being billed and Medicaid billing is now applicable, do providers need to submit the existing OASIS submitted to Medicare with the new Medicaid episodic billing or will Medicaid electronically access that information from the Medicare system?

The Medicaid episodic payment system has no data link to OASIS information from Medicare. Providers will not submit OASIS data to the Department; Medicaid billing will be determined by the provider utilizing the rate code generated by applying the OASIS assessment information to the Medicaid grouper logic. As noted in the answer to a previous question, a new occurrence code of 50 has been established on the UB-04 claim for assessment date, that will provide the audit/tracking link to the OASIS assessment data the provider utilized for Medicaid billing.

EPISODES

1. If the certification period for a patient begins on April 1, 2012, and the episodic system takes effect May 1, will Medicaid billing be handled Fee for Service from April 1st thru the 30th and then a partial episode payment made for May 1st thru May 30th? Would partial episodic or LUPA payments be made for the shortened periods after 04/30/2012?

FFS billing and payments will continue as authorized and applicable through April 30, 2012. In order to transition to episodic coverage for existing patients, providers would initiate a Medicaid episode beginning on May 1st. Payment will be based on the most recent OASIS assessment (must be no more than 60 days prior to beginning of Medicaid episode).

OASIS assessments will continue to be completed in accordance with Federal requirements. If the provider wishes to synchronize the Medicaid episodic dates with the existing assessment schedule, the agency should submit a claim for a partial episode ending May 30, then switch to full 60-day episodes if the patient remains under care.

Payment for a partial episode will be pro-rated unless the patient is discharged to home, hospital or hospice, or is deceased. If total service cost is \$500 or less, claim will be paid as a LUPA.

2. For cases already in a second or later episode/cert period prior to May 1st, will episodic payment begin with what is considered a Start of Care episode paid at a lower rate or a subsequent episode paid at a higher rate?

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

The rate to be used for Medicaid billing will be based on the most recent OASIS. If the most recent assessment was a "Recertification," the NYS Medicaid rate will be based on Recert., even if it is the first episode billed to Medicaid.

3. When a patient is receiving Medicare only benefits, but then requires Medicaid eligible services at a date subsequent to the start of home health care, how should episodes be kept in synch? (e.g. - On day 35 of a Medicare episode it is determined that patient no longer meets Medicare billing criteria, or begins to receive additional home health aide hours billable to Medicaid) How/When should the Medicaid episode be created if part of the services are to be billed to Medicaid and part continue to be billed to Medicare? Is one possibility to bill Medicaid-covered services for the above patient as fee for service until the next cert period and then synchronize episodes? How should the episode be created if all of the services shift from Medicare coverage to Medicaid?

The authorization to bill fee-for-service ends on May 1, 2012, except for children under 18 years of age. An initial Medicaid episode commences with the date of the first Medicaid eligible service. No Medicare covered services can be included in the Medicaid episodic claim. To synchronize subsequent episodes with the federally required OASIS assessment cycle, the initial Medicaid episode would be submitted with DOS covering the initial partial period (as claimed on UB-04, field 6 "Statement Covers Period From/Through") and a partial episodic payment would result.

Example: Medicare episode is April 15 through June 13. Medicaid eligible services begin May 20. If the agency wishes to synchronize episodes, the initial Medicaid claim will be for May 20 through June 13 (partial episode). Subsequent Medicaid claim will be for June 14 through August 12 (full episode).

4. If a patient is receiving Medicaid only services and then becomes Medicare eligible, a new SOC OASIS is completed for the Medicare episode. How should providers keep episodes in synch? Should original Medicaid episode be ended and create a new one, resulting in a PEP to the Original? If not, OASIS will be out of synch for the two payers.

A partial episode can be used for Medicaid to keep the Medicaid and Medicare episodes in synch. If all services become ineligible for Medicaid (i.e. Medicare covered), the Medicaid episode would end, and based on the dates of Medicaid service as claimed on the UB-04, a partial episode and corresponding partial payment would be determined.

5. If a patient is dually eligible and the CHHA is billing for both Medicare and Medicaid, there may not be a visit on the first day of the Medicaid episode for a SOC case, as the home health aide may not go into the home until a few days after the SOC. Will it be acceptable that the first visit falls after the Start of Care Date?

A Medicaid initial episode cannot begin until a Medicaid eligible service is provided. This is consistent with Medicare payment rules. For a second or later episode the subsequent episode begins on the day after the end date of the previous episode, provided the patient is receiving continuous care.

There is an exception which applies only to May 1, 2012: If the patient was receiving Medicaid-eligible services in April 2012, and care continues into May 2012 without a discharge, the initial Medicaid episode can begin May 1 even if there is not a Medicaid-billable service provided on that date.

6. How will partial episodes be calculated? Episode start thru last visit, or first visit thru last visit?

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

The partial episode is based on the dates of service as claimed on UB-04, field 6: "Statement Covers Period From/Through".

7. If a patient is discharged after one or two episodes and readmitted at a later date, does the episode counter start back at 1?

There is no episode "counter." Under this example, a start of care assessment would need to be completed for this patient.

8. How will the final payment adjustment work based on length of stay?

If the dates reported in UB-04 field #6 ("Statement Covers Period") reflect 60 days or more, provider will receive payment for a full episode. For periods of less than 60 days, the payment amount will be pro-rated unless the patient was discharged to home, transferred to a hospital or hospice program, or is deceased.

Beginning May 1, 2012, these exceptions will be determined by the Discharge Status reported by the provider (field 17 on the UB-04). This logic will not be available during the testing period (Jan. 4, 2012 through April 30, 2012) and all reported episodes of less than 60 days will be pro-rated.

9. If there is a concept of billing episodes, do all active patients on 5/1/2012 have their billing episodes start new on 5/1/2012 or would they convert to episodic payments at recert time?

FFS billing for patients 18 and older is not valid after April 30, 2012. For patients under continuous care in April and May, the first episode will start May 1. For a new patient in May, first episode will begin on the date of the first Medicaid eligible service.

10. What is the claim procedure when a CHHA discharges a patient to the home/community in less than 60 days, and then readmits the same patient before the end of the 60-day episode?

If the agency has already filed a Final Claim and then provides additional services within the 60-day period, an Adjusted Claim will be required. All services within 60 days of the original episode start date will be considered part of the same episode.

11. If a patient is hospitalized during the 60-day period do we discharge, and re-admit once the patient is discharged from the hospital, or do we handle this like Medicare, where the patient remains in "pending" until the 60-day episode runs out?

All CHHA services within the 60-day period should be billed as a single episode. If the agency has already filed a final claim reflecting less than 60 days, and then resumes care for the same patient, an adjusted final claim should be filed.

12. Explain what the statement from and thru dates reflect on the claim; would that reflect the billing cycle?

The from and through dates represent the beginning and end of the episode. If this is the first Medicaid episode, the from date coincides with the date of the first Medicaid eligible service. The through date is either the end of the 60-day period, or the last date services were rendered, if the episode is a partial. For subsequent episodes, the from date is the date immediately following the through date of the previous period. The through date is populated following the same rules as the initial episode.

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

13. If a patient receives Medicaid FFS and is under the age of 18, however has a birthdate within the next 60 days, how should the Episode be reported? If the patient turns 18 and only has 30 days within the episode, will an adjustment be required?

Services provided to a patient under age 18 must be billed on a fee-for-service basis (not episodic). Episodic billing for the patient will begin on his/her 18th birthday, provided that a Medicaid eligible service is provided on that day; otherwise, the episode will begin on the first day after the 18th birthday that a Medicaid eligible service is provided.

If the episode begins on the patient's 18th birthday and ends 30 days later, it will be reimbursed as a partial episode, unless it meets one of the criteria for full episodic payment (e.g. discharge to home).

14. Should the patient be discharged from the Medicaid FFS program on the day before his/her 18th birthday?

There is no need to discharge the patient. Services must be billed FFS prior to the 18th birthday, with episodic billing starting at age 18.

15. Many of our customers have conveyed that they are on a 6 month certification cycle, rather than a 60 day cycle. Would these agencies be required to complete a certification assessment prior to or on May 1, 2012 in order to have a current 60 day certification to use for beginning the episodic cycles?

Federal CMS rules require completion of an OASIS assessment for home health patients no less frequently than every 60 days.

PRICING METHODOLOGY

1. What is the standard rate?

The base price (representing a case mix of 1.00) under the episodic payment model is \$5,633.

2. What are the case mix weights?

The case mix weights are listed under "EPS – Base Price, Resource Groups, Case Mix Indices, Outlier Thresholds, Rate Codes."

3. What are the CBSA or similar adjustments to the standard rate?

The base price will be adjusted by a Wage Index Factor which uses 10 Labor Market Regions as determined by New York State Department of Labor. Preliminary wage factors will be released for the testing phase (begins Jan. 4, 2012) and final factors will be determined prior to April 1, 2012.

4. Will the Wage Index be the same as Medicare and will it be effective on the same dates?

The Wage Index Factor will be used to equalize labor price differences within the state. Since the payment system is based on NYS expenditure data, the Medicare wage factors, based on differences in national labor markets would not be applicable. Changes to the index values may not occur at the same time as Medicare revisions.

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

5. Will the wage index be based on the county where the service is performed, patient's home, or the county where the agency is licensed?

The applicable wage index will be based on the Locator Code for the billing agency.

6. Regarding the HHA volumes in the weighted calculations for the overall wage index per region, were those in visits or hours?

Weighting was based on reported visits.

7. Is there a labor and non-labor portion of the visits and episodes?

Yes. The labor percentage applicable to the Wage Index adjustment component of the payment methodology is 77%.

8. Will a LUPA be identified as an episode with 4 or fewer visits, similar to Medicare LUPA identification?

No, the Low Utilization Payment Amount (LUPA) threshold is \$500 as determined using statewide weighted average rates.

9. What are the LUPA rates ?

Rates to determine the underlying cost of services for both LUPA and outlier calculations will be based on the statewide weighted average of the most current fee-for service rates at the time of 5/1/12 implementation.

10. Is there an outlier calculation for high utilization cases? If so what is the outlier loss sharing rate? Yes, there is an outlier payment determination, which is set at 50% loss sharing.

11. Is there a LUPA add-on for SOC episodes?

No.

12. Will the number of therapy services be factored into the calculation?

No.

13. Does the dollar figure change based on early/late billing episodes?

The case mix adjustment to the price (as determined by the Medicaid grouper) varies depending on whether the OASIS assessment is a Start of Care assessment or a Recertification (see the 108 case mix groups).

14. Is the final episodic price based on the initial OASIS or the ending OASIS?

Final payment will be based on the billed Rate Code, which should correspond to the most recent OASIS completed on or before the start date of the episode.

15. When the episode is an Outlier PEP, do we have to recalculate case mix's outlier threshold amount? That is, do we have to see that the episode is a PEP first, get the number of days and then prorate the outlier threshold to those days before comparing costs to outlier threshold?

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

The outlier threshold will not be prorated for partial episodes. The total payment amount for a full 60-day episode, including any outlier component, will first be computed; then the total will be prorated if the episode is less than 60 days and does not qualify for one of the exceptions to partial payment adjustments.

16. Agencies are allowed to complete an OASIS RFA-03 when the patient returns from a hospital stay within the last five days of the previous episode to calculate the EEP for the next episode. Is your intention to keep this logic? Or, are you stating that the calculation will be based on the RFA completed regardless of Initial episode or Subsequent episode?

The billed rate code must be consistent with the most recent OASIS assessment on or before the first day of the billed episode. If a provider completes a new assessment five days before the end of a Medicaid episode, the new assessment will determine the rate code to be used for the next Medicaid episode.

17. With the release of the 2012 Initial Rates for CHHAs we have received some questions as to how providers will be expected to handle (deal with) the workforce add-on monies (3% and 4.7% RT&R) monies with the implementation of Medicaid EPS 5/1/12? Will you be issuing further instructions on this.

The recruitment and retention funding, as well as the provider requirements on use of the funding, remain in effect in accordance with current statute (PHL 3614.8 and 9-10) through March 31, 2014. The Medicaid episodic methodology payment prices have been determined to include the full amount of the statutorily authorized funding for CHHA's. Under Medicaid episodic payment agencies will continue to be required to properly provide such funding to direct care workers and to continue to account for the funding in accordance with requirements detailed in the above – noted statutory provisions.

NYS MEDICAID GROUPEUR

1. Will DOH or a 3rd party distribute a grouper module or will vendors/providers need to write their own?

NYS will not be distributing a grouper module. Providers will need to create their own module which will generate one of the 108 rate codes to be used to bill on the Medicaid claim.

2. What technology will the grouper module be developed in (java, .net, dll, etc.)

The technology used for development of the module is a provider decision.

3. What are the grouper variables and how are they factored in?

Age, clinical, functional, and type of assessment are the four components in determining group.

4. The HIV group includes the code group 795.8 Abnormal Tumor Markers. This code requires 5 digits. Does DOH plan to include all codes with the first 4 digits of 795.8? In the other groups DOH specified the 5 digit codes.

There are 3 codes in that group and they were valid in 2009:

795.81 elevated carcinoembryonic antigen (CEA)

795.82 Elevated Cancer antigen 125 (CA125)

795.89 Other abnormal tumor markers

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

From 1986 to 1994, '7958' was a valid code for HIV Infection - Positive Sero/Viral HIV. So, '7958' is valid, if it appears. '79581', '79582', '79589' are not valid codes for HIV Infection.

5. Are the diagnosis codes referred to in the SAS the primary only, the primary and the next X number of diagnosis codes associated with the assessment? There are 6 diagnosis codes associated with an assessment; do we interrogate all of the six for any of the category values for the Grouper?

When looking at the diagnosis codes you can look at all six (primary and 5 secondary) diagnosis codes listed in the assessment.

6. In the Medicare grouper there is a table of allowable pairings of etiology and manifestation codes. If these codes are not both listed the case mix points are not awarded in the calculation of the HHRG. I noted in the dementia codes the listing of 294.10, 294.11. These are both manifestation codes for the etiologies codes: 331.0, 331.11, 331.19 and 331.82. Will we need to code both to obtain the case mix points as in the case of the Medicare grouper?

No, the NYS Medicaid Grouper will not be looking for pairings of etiology and manifestation codes.

7. I am assuming only one code in a group will receive points in the grouper. For example the patient may have diabetes with a neurologic manifestation (250/6x) and diabetes with a peripheral circulatory manifestation (250.7x). In this situation am I correct in understanding I would receive 4 points only for both codes?

That is correct; a maximum of four points can be awarded for diabetes regardless of the number of diabetes related ICD-9 codes listed. Diabetes is valued at 4 points, Orthopedic is 2, Dementia is 24 and HIV is 10 points. If the patient has a dx of diabetes and HIV - that person would receive 14 points (4 +10).

8. Is it your intention that when a category ICD is listed, all the qualified codes are to be included? For example you list (ortho code 170), are you including 1700, 1701, 1702, 1703, 1704, 1705, 1706, 1708, 1709. Is the ICD code 29420 redundant since you list the category of 294?

Yes, if the category ICD is listed, it is assumed that all qualifying codes are included.

9. Going forward, as ICD codes are added that effect reimbursement, how and when would those updates be relayed? Will the NYMA grouper be updated to accommodate them? Will the October 1, 2011 ICD changes be used? Will ICD10 be factored when applicable?

Yes, ICD10 changes will be factored in if applicable.

10. What will happen to the calculation if the ICD on an episode is not on the list that is provided?

If the ICD is not part of the algorithm, it will not be counted.

11. When the next generation of OASIS is released, how quickly will NYMA update their system?

The episodic payment system will continue to be evaluated for changes in data elements and any other adjustments that may need to be applied to ensure the continued accuracy of the payment model in the evolving transition of patients to managed care.

12. What is the timeframe for completion of OASIS assessments?

EPISODIC PAYMENT SYSTEM FOR CHHAs Updated Q&A

March 27, 2012

Timeframes for completing the OASIS do not change and will continue to follow federal guidelines.

ADDITIONAL INFORMATION

1. Is there a period of time that you will be accepting Fee for Service claims and PPS claims at the same time?

For dates of service May 1, 2012 and subsequent, FFS claims will be accepted only for patients under age 18. Claims for dates of service before May 1, 2012 will be accepted after May 1 for patients age 18 and older.

2. Will there be any comparisons between agencies pertaining to Clinical Outcomes? Are you moving forward to a PFP model based on outcomes?

The Department is currently working on various approaches to assess clinical outcomes and performance. These approaches may be implemented in the future, but at this time it is not anticipated they will be implemented prior to the May 1, 2012 effective date of the episodic payment system.

3. Provide details on the testing phase:

Who can test, how, and when can testing start?

Can Test Data be sent Hard Copy or in the electronic format?

The Provider Test Environment (PTE) only accommodates electronic transactions. Anyone billing electronic 837I claims can begin testing in the PTE as of Jan. 4, 2012. Hard copy test data is not allowed. Testing will accommodate dates of service beginning Nov. 1, 2011. More information is available here:

<https://www.emedny.org/hipaa/5010/transactions/>

4. Will vendors be allowed/required to test the episodic billing? If so, will 'real data' be required? And if so, will our customers inherit our approval if and when we pass testing?

Testing in the Provider Test Environment (PTE) is allowed but is optional. 'Real data' will be required. DOH does not impose any formal approval process.

5. What are you doing to make sure all the billing software vendors will be ready for April 1, 2012?

Informational materials regarding the Episodic Payment System have been distributed to vendors as well as providers, and the Department has been in direct contact with vendors to assist them with preparations for the changes in payment methodology.