Billing Considerations

For the Co-location of Primary Care and Behavioral Health Services

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Introduction

Today's Presenter

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Grassi & Co.

General partner questions and comments will be addressed today via the chat function.

Agenda

1. Introduction
2. Impact of Co-location of Services on Billing & Claims
3. Solutions Overview
4. Considerations for Billing & Coding Changes
5. Compliance
6. Additional Resources
7. Q&A

Introduction

- Under NYS DOH, integration of mental health and substance abuse services with primary care services is a critical component of DSRIP transformation
- This webinar describes billing and billing compliance considerations for both the co-location of behavioral health* into primary care and the co-location of primary care into behavioral health

* For the purposes of this presentation behavioral health means mental health & substance abuse services

Introduction

Billing and compliance considerations will be described for the following regulatory options:

1. Licensure Threshold
2. DSRIP Waiver
3. Integrated Outpatient Services (IOS) License

Billing and compliance considerations will NOT be described for the following regulatory options:

1. Dual Licensure for One Agency
2. Two Providers with Different Licenses (shared space)
   - For these regulatory options, there are no changes to current billing processes under the host licensure and new modifiers & rate codes do not apply

Please refer to the recording of the regulatory options webinar for more information on these five regulatory options:
http://www.onecityhealth.org/webinar-available-view-regulatory-options-co-location-primary-care-behavioral-health_060117/

Key Definitions & Acronyms

APG – Ambulatory Patient Groups – a classification system used to support an payment methodology for outpatient services developed by CMS and also used by NYS for Medicaid/Managed Medicaid for certified clinics

AR – Accounts receivable

Behavioral health (BH) services – Mental health (MH) services and substance use services (SUD)

Co-location – As defined by NYS Guidance on Space Arrangements, separately owned clinics sharing a location

DSRIP – NYS Delivery System Reform Incentive Payment Program

EHR – Electronic Health Record

Host site – A "host site" is defined as a single outpatient site licensed or certified by DOH (Article 28), OMH (Article 31) or OASAS (Article 32) that is approved by its licensing agency to integrate "other" services as prescribed under the regulations.

PPS – Prospective Payment System

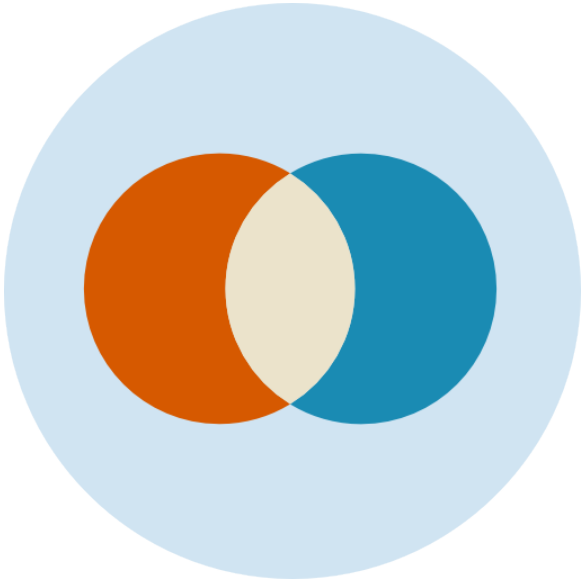
Shared space – As defined by NYS Guidance on Space Arrangements, two clinics owned by the same entity sharing space to deliver integrated services

Impact of Integration of Services on Claims

- Prior to integration, separately licensed clinics or providers were often on disparate EHR and/or billing systems
- Systems will need to be adjusted to accommodate the newly integrated services in order to bill via a **merged APG or PPS claim** for services provided on the same day
- Integrated systems will need to accommodate different behavioral health and physical health payers depending on the service type as appropriate to the patient's plan
- A single system solution that integrates patient and billing system data files for the integrated services is preferred whenever possible

Merged Claims for Same Day Primary Care and Behavioral Health Services

- “Merged” claims are always tricky regardless of whether its all primary care or all behavioral health and with integrated services it could get trickier. “Merged” = Institutional APG or PPS claims. A “merged claim” is defined as all same day or same encounter multiple provider services coming together on a single claim.
- Even in the current environment, there may be contact with more than one provider on the same day or in the case of primary care across multiple days
- Integration means more provider contact & therefore increased numbers of same day services that potentially need to come together on the same claim whether it be a primary PPS or APG claim or whether it be the crossover claim that began as multiple professional claims and ended as a merged institutional claim

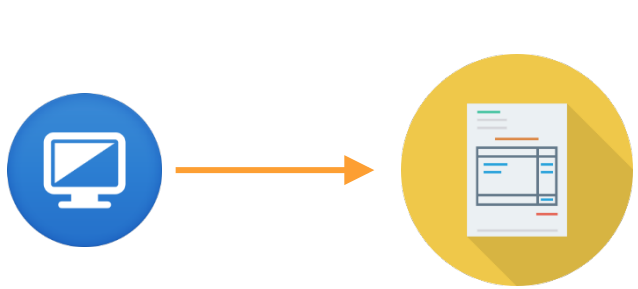


Front End Documentation Considerations

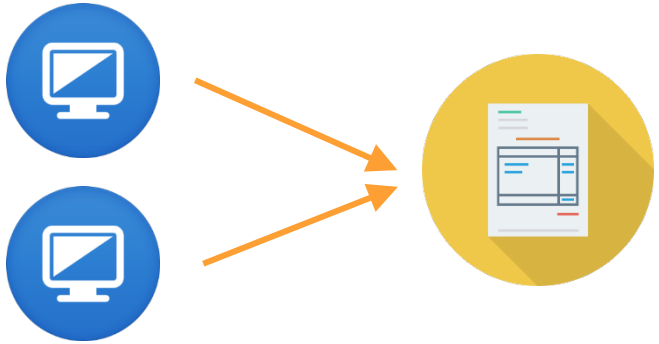
Area	Consideration
Scheduling →	Staff should have access to a scheduling tool that can view and book integrated visits
EHR →	Clinical staff should have appropriate edit/view access to templates for host and integrated services. Clerical staff should have role specific access to appropriate data
Billing →	All integrated service coding data must migrate to a single billing software database to create merged claims when necessary

Documentation Workflows: Possible Billing Solutions

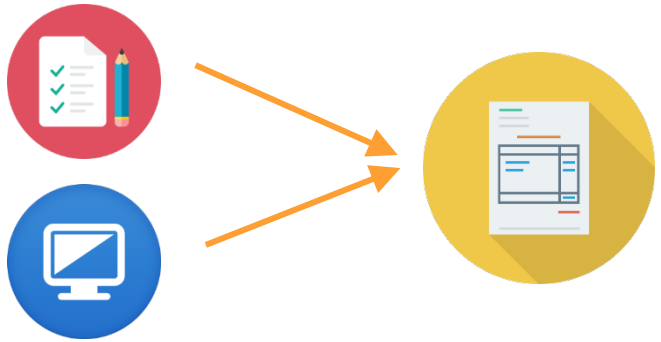
How will integrated service coding data migrate to a single billing software database to create merged claims when necessary?



1. Integrated providers will use a single integrated EHR for all service documentation and claims will “naturally flow” to a single billing system or into the practice management side of the software



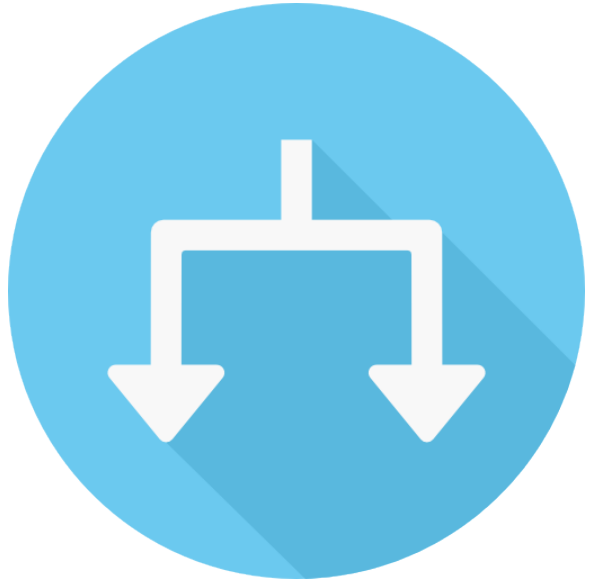
2. Integrated providers will continue to use separate EHRs and coding data will migrate to a single billing system



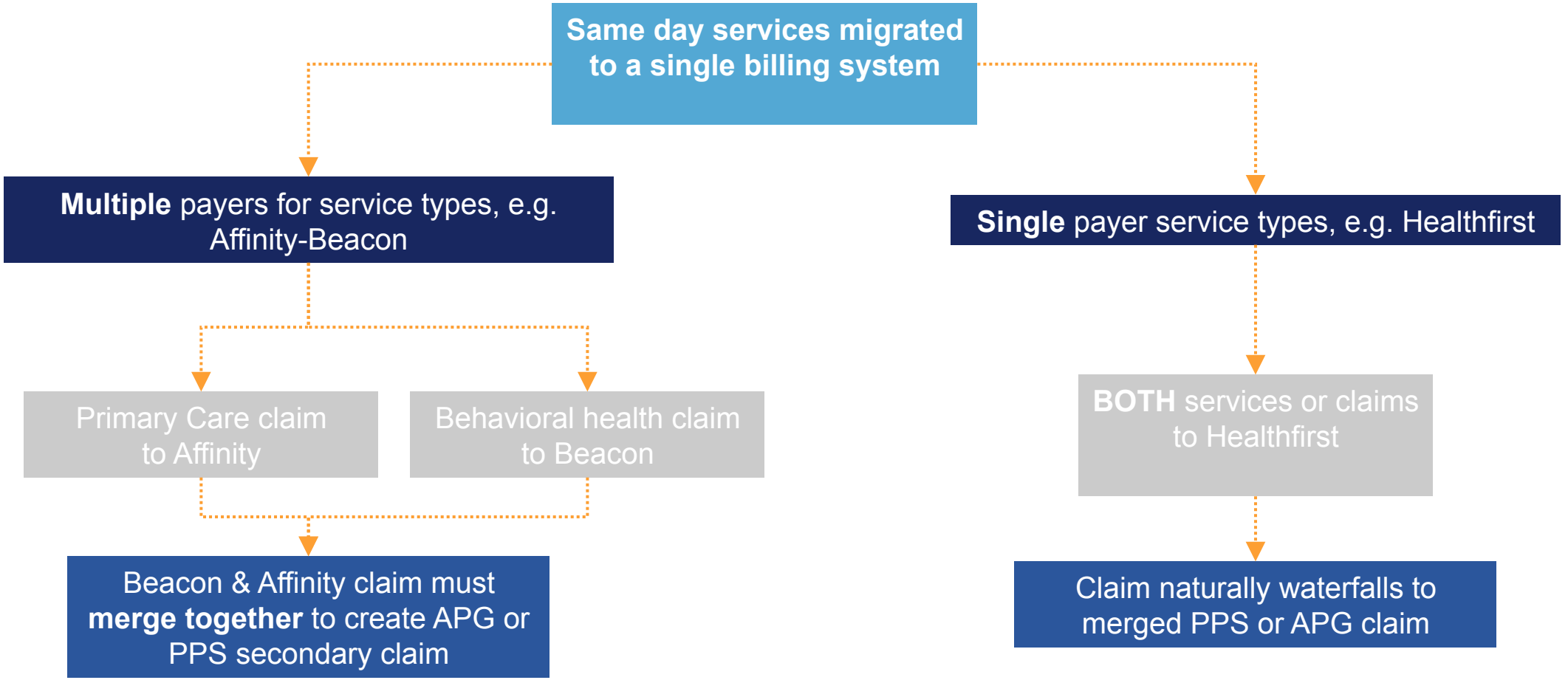
3. Integrated providers will continue to use a separate EHR system and paper records and coding data will migrate to a single billing system

Considerations for Merged Claims

- “Splitting” claims is just as challenging as merging claims when the claim is an APG or PPS claim and where the payer has a sub-contractor for their behavioral health services
- Automated or manual workflow processes that accommodate this “splitting & merging” are critical to successful & timely reimbursement.
- Implementation of billing system processes to prevent “singleton” claims from being submitted to payers when multiple services same day should come together as a single claim on a single day to the same payer or vice versa is key to your success



Merged Claims for Same Day Primary Care and Behavioral Health Services



APG Billing Changes

	Regulatory Options		
Change	1. Licensure Threshold	2. DSRIP Waiver	3. IOS License
Rate code	No change	New integration rate code effective date of waiver approval	New integration rate code effective date of license approval
Reimbursement	No change	Host site APG rate	Host site APG rate
Ancillary Services	No change	Ancillary services policy applies to all services in an A28 or A32 host (DOH currently reviewing impact of PC integration into BH clinic)	Ancillary services policy applies to all services in an A28 or A32 host (DOH currently reviewing impact of PC integration into BH clinic)
Modifiers	No change	New modifiers added & modifiers in development – watch closely for updates that impact reimbursement*	New modifiers added & in development – watch closely for updates that impact reimbursement*

*NYS Integrated Services Overview – July 2016 https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2016-07-14_integrate_serv_webinar.pdf

APG Billing Changes

Integration Rate Codes (DSRIP Waiver & IOS License)

- For the DSRIP waiver or IOS license, there are new rate codes (RC) based on the host site and regulatory option
- New RCs will allow for primary care & behavioral health APG claims to bill together as a merged claim beginning the effective date of waiver approval or certification
- No change to FQHC Medicare PPS or Medicaid PPS rate codes

Article 28 Host – DSRIP Waiver	Article 28 Host – IOS License
1102 – Freestanding DTC – APG	1597 – DOH Freestanding DTC – APG
1104 - Hospital OPD – APG	1594 – DOH Hospital OPD – APG
DOH – FQHC – *No change* to rate code	DOH – FQHC – *No change* to rate code
Article 31 Host – DSRIP Waiver	**Article 31 Host – IOS License**
1106 – OMH Freestanding DTC - APG	1480 – OMH Freestanding DTC –APG
1110 – OMH Hospital OPD – APG	1122 – OMH Hospital OPD – APG
Article 32 Host – DSRIP Waiver	**Article 32 Host – IOS License**
1114 – OASAS Freestanding DTC - APG	1486 – OASAS Freestanding DTC –APG
1118 – OASAS Hospital OPD – APG	1130 – OASAS Hospital OPD – APG

* NYS Integrated Services Overview – July 2016 https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2016-07-14_integrate_serv_webinar.pdf

APG Billing Changes

Integrated Same Day E/M Coding

Change	Licensure Threshold	DSRIP Waiver & IOS License
XP Modifier	No change	XP modifier on BH integrated service E/M = pay for both
Diagnosis (dx)	No change	1st E/M listed - Primary claim dx = Primary Care 2nd E/M listed - Secondary claim dx = Behavioral Health
Systems	No change	System must be able to identify & append XP modifier to behavioral health E/M code (line 2) or manual intervention required for proper reimbursement
Discounting	No change	No discounting 2nd E/M -10% BH multi service discounting eliminated in approved integrated services clinics

* NYS Integrated Services Overview – July 2016 https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2016-07-14_integrate_serv_webinar.pdf

APG Coding

Template Considerations for Integration

DOH has been silent on whether they will require an A28 PC host integrating BH services to use the OMH & OASAS modifiers. Common modifiers as follows and clinics should be prepared to integrate them into their EHR & billing system.

Primary Care Integrating Behavioral Health Services- Modifiers	
U4 Modifier	OMH - Add to array of accessible modifiers – use for 20 min psychotherapy service
U5 Modifier	OMH service delivered in a language other than English
KP Modifier	OASAS 1st weekly visit Methadone
AG Modifier	OASAS - MD providing a typical counselor service
AF, AG, SA Modifier	OMH Physician add-on - AF (psychiatrist), AG (Physician) or SA (Nurse Practitioner – Used when an MD, NP, psychiatrist spends at least 15 minutes participating in the provision of services being provided by another licensed practitioner or when the therapy service is provided fully by a psychiatrist/MD/NPP.

APG Coding

Template Considerations for Integration

Claims edits and considerations	
Claims Edits - Service Duration	OMH/OASAS specified CPT (service) durations 15 min, 30 min, 45 min, etc.
Claims Edits - Treatment Plans	In an integrated OP service model PC host an integrated treatment plan must be completed w/ in 30 days of decision to begin post-admission BH treatment
Psychological Assessments - Utilization Edit	OMH 1-3 Allowable 365 days – Medicaid/MMC primary payer ONLY

FQHC Claims

While in general, the FQHC claiming methods do not change except once integrated to reflect both primary care and behavioral health same day services on the same claim, there is a change to the expected reimbursement.

Payer	Impact
Medicare	Change - **Two** PPS payments same day for primary care & behavioral health services
Medicaid	No change - Single PPS payment for both service types on the same day
Crossover claims	NYS in the process of addressing dual eligible crossover claims for co-insurance

Compliance Consideration: Threshold Tracking

Regulatory Option	Consideration
1. Licensure Threshold Tracking →	In order to comply with threshold regulations, develop a process to track the % of integrated service encounters provided* * NYS agencies will not track services under the current licensure threshold
2. DSRIP Waiver Threshold Tracking →	In order to be complaint with the waiver up to 49%* of total annual visits provided in the host site may be the integrated service(s). Develop a tracking method in lieu of NYS agency tracking to prevent a revenue loss or takeback* * NYS agencies tracking is under development, until then providers must track their own service % under the DSRIP Waiver threshold
3. IOS License No tracking →	Tracking of visits is not necessary because there is no visit threshold for integrated services.

A Final Compliance Note

Consent for Treatment

- From a compliance standpoint, consents for treatment that align with state & federal regulations are key
- Current consent documents and procedures used by each individually licensed clinic should be reviewed and integrated to ensure they adhere to all regulatory standards for the delivery of all integrated care
- Ultimately no consent means no payment if audited and appropriate consents were not in place at the time of treatment

Notice

This webinar provides guidance on billing and compliance considerations for the integration of behavioral health and primary care services under various models, but is not intended to replace a health care organization's independent legal, regulatory, and financial analysis as part of its internal planning activities. Rates may be impacted by contracts, contracting activities and model type selected. In addition, please note that the legal, regulatory, and financial environment is subject to change over time.

The material in this presentation is based on written guidance from various state agencies available as of December 14, 2016, and conference calls with representatives of the Department of Health and the Office of Mental Health for clarification. The referenced documents are:

Additional Resources

- Article 28 - DOH licensed providers (10 NYCRR Part 404):
- Article 31 - OMH licensed providers (14 NYCRR Part 598)
- Article 32 - OASAS licensed providers (14 NYCRR Part 825)
- NYS Integrated Services Overview
- Frequently Asked Questions: Approaches to Integrated Care Aug 2016
- Integrated Outpatient Services-Implementation Guidance
- NYS DOH Statewide Guidance on Space Arrangements Between Two or More Providers October 2016
- Guidance for DSRIP Performing Provider Systems Integrating Primary Care and Behavioral Health Services under Project 3.a.i
- NYS Ancillary Services Billing Policy
- NYS DOH APG Manual
- NYS OASAS APG Manual
- NYS OMH Clinic Treatment Programs Interpretive/Implementation Guidance

NYS Agency Contact Information

NYS Department of Health (DOH) –
Division of Program Development & Management
(518) 473-2160

NYS Office of Mental Health (OMH)
(518) 474-6911

NYS Office of Alcoholism &
Substance Abuse Services (OASAS)
(518) 473-3460

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Questions?

For more information

ONECITY HEALTH SUPPORT DESK:

Call 646-694-7090

Email ochsupportdesk@nychhc.org with the subject line “PCBH Integration Question”

Hours of Operation:
Monday through Friday
9am to 5pm ET

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