MAPP HHTS
Bi-weekly Webinar

July 12, 2016

MAPP HHTS Review of Frequent Questions to MAPP Customer Care Center

Creating a segment for member w/ active or pending assignment with another HH/CMA

- If a member that you have established a relationship with has an active or pending assignment with another HH/CMA (HH 2), but no active segments, you can enter the member enrollment with your organization (HH 1)
  - Use the **referral wizard** - Under Quick links on the home page; Click on create referral/segment; After entering the members CIN you will get a warning message indicating that the member is assigned to another organization but will be able to proceed; **OR**
  - Submit **Tracking Segment Record file** with a value of 'R' in the referral indicator field.

- Once the segment is created, the member will no longer appear on HH 2 assignment's file and will appear on HH 1 enrollment download file

- If the member has an active segment the referral wizard/file upload will not allow you to proceed

Using the Billing Support Download file to determine which member to bill for

1. Download the billing support download file from MAPP HHTS

2. Filter the **Billing Entity MMIS ID** to your MMIS ID
   - This ensures that you are the appropriate biller for the service
   - Double check that none of the remaining claims have a direct billing indicator of 'Y'.

3. Filter the **Add/Void indicator** to 'A'
   - This indicates that a billing service was added

4. Filter the **Core Service Provided** to 'Y'
   - This indicates that a service was provided and a bill can be submitted

5. Filter **Latest Transaction** to 'Y'
   - This ensures that you are looking at the latest information when submitting billing information

6. Filter **Service Date** to the dates you wish to bill for

Errors in Billing

The BSD file can be used when a bill was submitted in error

1. Use the **Void indicator** to indicate that the instance was submitted in error

2. If appropriate, re-submit the instance correctly
   - Examples:
     - Direct billing indicator was incorrect
     - HML assessment was incorrectly added (no services were provided)

As a billing entity it is your responsibility to review voided billing instances and adjust your billing with Medicaid as appropriate

1. Download the BSD file

2. Filter **Billing Entity MMIS ID** to your MMIS Provider ID

3. Filter the **Add/Void Indicator** to 'V'

4. Be sure to look back at **Service Date** in the past- This will ensure that you don't miss any voided claims

A voided billing instance may require you to do a bit of investigation to determine if you need to rectify the billing with Medicaid - i.e. was this the latest transaction? Did I bill for this instance previously or not?

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Importance of reviewing reason codes

- Segment end date, assignment rejection, and assignment end reason codes are used by providers to indicate why their association with a member is ending. MCP/HH must pay attention to these reason codes when determining what to do with the member. Providers should review the various reason codes and develop internal processes for handling each code (possible processes described below).

  - MCP sees that a HH assignment was rejected with reason code 02 (Member moved out of service county), so MCP looks up member's current address and re-assigns member to different HH that services that area

  - HH sees that a CMA ended an assignment with reason code 03 (Member has a new CIN). HH works with CMA to get member assignment under correct CIN

- The different segment end date, assignment rejection, and assignment end reason codes **DO NOT** trigger different processes flows in the system.

- Members who refuse HH services, opt out of the program, or have moved out of state, will remain assigned to the member's MCP until the member's plan enrollment ends.

- Right now, MCPs can only pend a pending MCP Assignment. In a future release, MCPs will also be able to pend an active MCP assignment.

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Restriction Exception (RE) and Coverage Codes

Coverage Codes

- Within Medicaid, all members have a **coverage code** that describes a member's Medicaid coverage. Some Medicaid coverage types only cover certain services and other coverage codes include care management services. Based on a member's coverage code, a member may or may not be compatible with the Health Home program.
    - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_coverage_codes.pdf

Restriction Exception Codes

- Some members also have **restriction exception codes**, which are used to describe a member (e.g. RE code H9 means that a member is HARP eligible; RE code 23 means that a member is in an OMH children's waiver program). Based on a member's coverage code, a member may or may not be compatible with the Health Home program. If a member's coverage code is listed on the link below as incompatible with the Health Home program, then the Health Home claim for that member will not be paid by Medicaid.
    - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf

MAPP HHTS Implications

- If a member's coverage or RE codes are listed on the links above as incompatible with the Health Home program, then the Health Home claim for that member will not be paid by Medicaid.

- If a segment is submitted on a file for a member with coverage /RE codes that are incompatible with the HH program as of the segment begin date, then the system will reject the record. If you'd still like to enter a segment for the member, then segment can be submitted to the system using the referral wizard.

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