Billing and Claims Overview: New York Medicaid and Wellness4Me

October, 2015

United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum
BH370_102015

Wellness4Me Plan (HARP) and Mainstream Medicaid

Covered Benefits for Wellness4Me and Mainstream Medicaid		
Services	Wellness4Me	Mainstream Medicaid
Medically Supervised Outpatient Withdrawal (OASAS Services)	Covered	Covered
Outpatient Clinic and Opioid Treatment Program (OTP) Services (OASAS Services)	Covered	Covered
Outpatient Clinic Services (OMH Services)	Covered	Covered
Comprehensive Psychiatric Emergency Program	Covered	Covered
Continuing Day Treatment	Covered	Covered
Partial Hospitalization	Covered	Covered
Personalized Recovery-Oriented Services (PROS)	Covered	Covered
Assertive Community Treatment (ACT)	Covered	Covered
Intensive Case Management/Supportive Case Management	Covered	Covered
Inpatient Hospital Detoxification (OASAS Service)	Covered	Covered
Inpatient Medically Supervised Inpatient Detoxification (OASAS Service)	Covered	Covered
Inpatient Treatment (OASAS Service)	Covered	Covered
Rehabilitation Services for Residential SUD Treatment Supports (OASAS Service)	Covered	Covered
Inpatient Psychiatric Services (OMH Service)	Covered	Covered
Crisis Intervention	Covered	Covered

Wellness4Me Plan (HARP) vs. Behavioral Health Benefit

The Home and Community Based Services are ONLY available to members enrolled in Wellness4Me Plan (HARP).

HCBS will not start until 1/1/2016 to allow time for all HARP members to receive their full assessment and for Plans of Care to be documented.

HCBS Services for Adults Meeting Targeting and Functional Needs		
Services	Wellness4Me	Mainstream Medicaid
Rehabilitation • Psychosocial Rehabilitation • Community Psychiatric Support and Treatment (CPST)	Covered	Not Covered
Empowerment Services - Peer Supports	Covered	Not Covered
Habilitation • Habilitation • Residential Supports in Community Settings	Covered	Not Covered
Family Support and Training	Covered	Not Covered
Employment Supports • Pre-vocational • Transitional Employment • Intensive Supported Employment • On-going Supported Employment	Covered	Not Covered
Education Support Services	Covered	Not Covered
Respite • Short-term Crisis Respite • Intensive Crisis Respite	Covered	Not Covered
Non-Medical Transportation	Covered	Not Covered

Managed Care Technical Assistance Center

The Managed Care Technical Assistance Center (MCTAC) is a training, consultation, and educational resource for all mental health and substance use disorder providers in New York State.

Recent trainings:

- Integrated Managed Care Billing Guidance (guidance on how to submit clean claims)
- HCBS Service Cluster Webinar Series

Also available:

- Interactive glossary of terms
- Managed Care Language Guide
- Frequently Asked Questions
- MCO Plan Comparison Matrix

Website: http://mctac.org

Billing requirements

Requirements

- 837i claim form (institutional) electronic form
- UB-04 (institutional) paper form
- Value code “24”
- Medicaid fee-for-service rate code
- Valid procedure code(s)
- Procedure code modifiers (as needed)
- Units of service

Location of state billing and coding manual:

https://www.omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf

Mainstream Medicaid

New Carved-In Services

Ambulatory behavioral health services

- Assertive Community Treatment (ACT)
- OMH Clinic services
- Continuing Day Treatment (CDT)
- Comprehensive Psychiatric Emergency Program (CPEP)
- Intensive Psychiatric Rehabilitation Treatment (IPRT)
- Partial Hospitalization
- Personalized Recovery Oriented Services (PROS)
- Transportation
- Crisis Intervention

Assertive Community Treatment (ACT) services

- Billed once per month
- Use one rate code for the month's services
- Use the last day of the month in which the services were rendered as the date of service
- Use of rate code, procedure code and modifier combinations are required

OMH Clinic services

- Use of rate code, procedure code and modifier combinations
  - OMH Clinics, both hospital-based and free-standing, have been billing Fee-For-Service (FFS) under the Ambulatory Patient Group (APG) rate setting methodology, using rate code, procedure code, and modifier code combinations, since October 1, 2010
  - For non-SSI recipients enrolled in managed care, OMH Clinics have been billing Medicaid plans for those same rate code, procedure code, and modifier code combinations, and receiving the government rate (APG rate) for those services, since September 1, 2012
  - As of the effective date of the behavioral health managed care carve-in and the creation of the HARPs, we will cover OMH clinic services for all enrollees and mirror the APG rates as we do now for the non-SSI population

Continuing Day Treatment (CDT)

Recipient only:

- Billed on a daily basis
- Three tiers
  - 1-40 hours
  - 41-64 hours
  - 65+ hours
- Two types of visits
  - Full and Half day
- Combination of rate code, procedure code and modifier code(s)

Collateral, group collateral, preadmission and crisis visits:

- Billed separately from the regular CDT visits

Additional services

Comprehensive Psychiatric Emergency Program (CPEP)

- Billed on a daily basis
- Combination of rate code, procedure code and modifier code(s)
  - Brief Emergency Visit
  - Full Emergency Visit
  - Crisis Outreach Services
  - Interim Crisis Service
  - Extended Observation Bed

Intensive Psychiatric Rehabilitation Treatment (IPRT)

- Billed on a daily basis
- Combination of rate code, procedure code and modifier code(s)
- Reimbursement is provided for service duration of at least one hour and not more than five hours per recipient, per day

Additional services, continued

Partial Hospitalization

- Billed on a daily basis
- Combination of rate code, procedure code and modifier code(s) is dependent on the number of hours of service a day
- Reimbursement is provided for service duration of at least four hours and not more than seven hours per recipient, per day

Personalized Recovery Oriented Services (PROS)

- Reimbursed on a monthly case payment basis
- Use the last day of the month as the date of service
- Use of rate code, procedure code and modifier combinations
- All the line level dates of service must also be the last day of the month

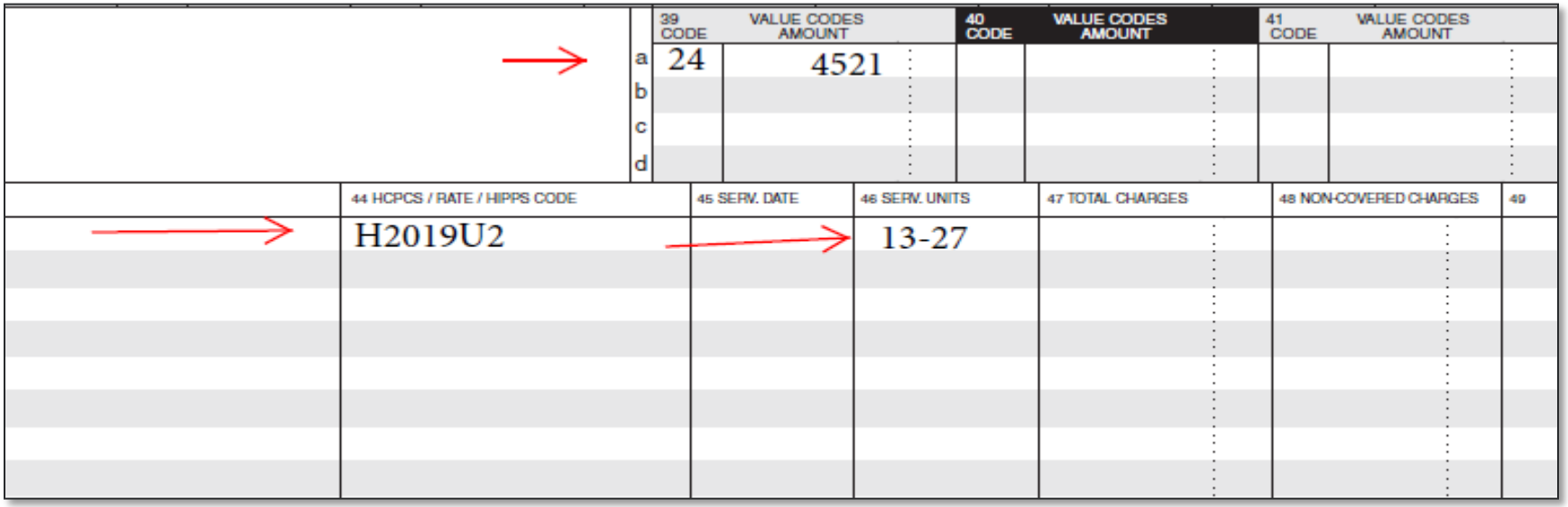
PROS cross-walk example

Prog	Rate Code	Rate Code / Service Title	Px Code	Modifiers	Units of Service	Modifier Definitions
PROS	4521	PROS COMM REHAB SRVCS 13-27 UNITS	H2019	U2	13-27	Level 2 (state-defined)
	4525	PROS CLIN TRMT ADD-ON	T1015	HE	1	Mental health program

Claim 1 – Rate code 4521 in the header (field 39 on UB-04) plus H2019U2 and 13-27 units at the line level (fields 44 and 46)

Claim 2 – Rate code 4525 in the header (field 39 on UB-04) plus T1015HE and 1unit at the line level (fields 44 and 46)

PROS example, UB-04

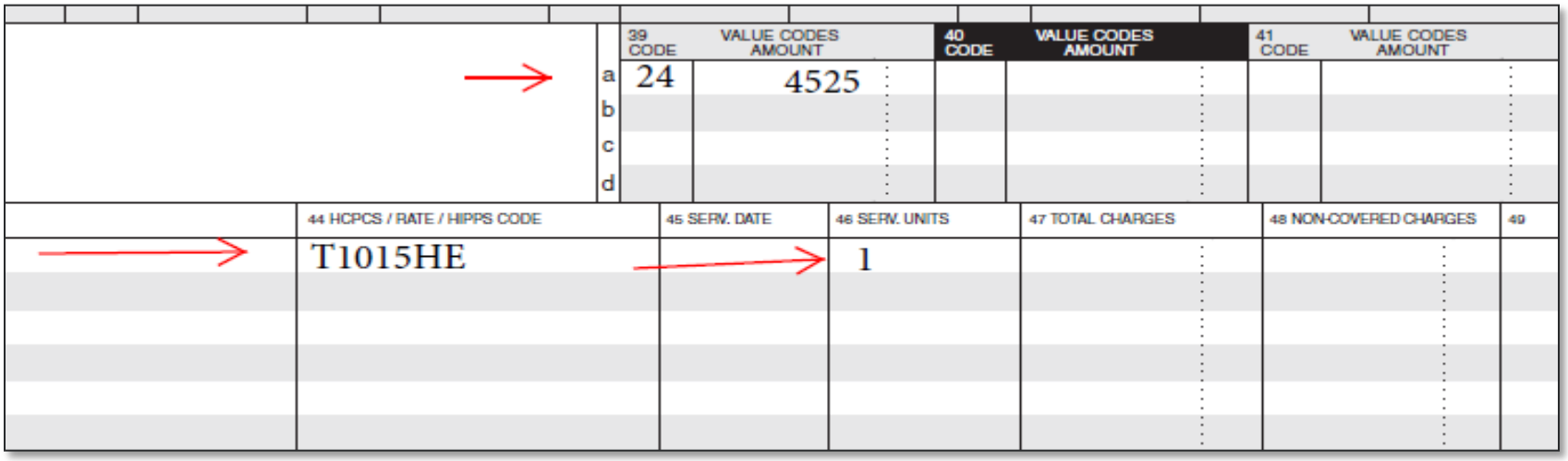


	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	24	4521				
b						
c						
d						

	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	H2019U2		13-27			

Claim 1 – Value Code 24 and Rate code 4521 in the header (field 39 on UB-04) plus H2019U2 and 13-27 units at the line level (fields 44 and 46)

PROS example, UB-04 continued



	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	24	4525				
b						
c						
d						

	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	T1015HE		1			

Claim 2 – Value Code 24 and Rate code 4525 in the header (field 39 on UB-04) plus T1015HE and 1unit at the line level (fields 44 and 46)

Transportation

Medically Necessary Transportation for Behavioral Health Services:

- Medically necessary transportation for behavioral health will be a carved-out service
- Bill directly to the state by the transportation provider

Non-Medical Transportation (only for Wellness4Me Members and individuals in HIV Special Needs Programs (SNPs) meeting the eligibility criteria based on the plan of care)

- Bill directly to the state by the transportation provider

Crisis intervention

- Provided off-site
- Fee includes transportation, do not bill separately
- Two separate types of sessions
  - Per hour
    - Billed daily in one hour units with a limit 4 units (4 hours) per day
    - Requires the participation of at least 2 staff (one can be non-licensed)
  - Per diem
    - Billed daily with a max unit of 1 (5+ hours)
    - Requires the participation of at least 2 staff

Wellness4Me: Home and Community Based Services (HCBS)

Covered Services

Wellness4Me: HCBS covered services

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment (CPST)
- Habilitation/Residential Support Services
- Family Support and Training (FST)
- Short-Term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Empowerment Services – Peer Supports (OMH)
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Transportation

HCBS billing requirements

Requirements

- 837i claim form (institutional) electronic form
- UB-04 (institutional) paper form
- Value code “24”
- Medicaid Fee-For-Service rate code
- Revenue code 0911
- Valid procedure code(s)
- Procedure code modifiers (as needed)
- Units of service

HCBS utilization parameters

HCBS will be subject to utilization caps at the Member level that apply on a rolling basis (any 12 month period).

- Tier 1 HCBS: limited to $8,000
- Tier 1 and Tier 2 combined have an overall cap of $16,000
- Utilization caps exclude crisis respite: short-term crisis respite and intensive crisis respite are each limited within their own individual caps to 7 days per episode and 21 days per year

Tier 1: Employment, education and peer support
Tier 2: Full array of HCBS

Psychosocial Rehabilitation (PSR)

- Use of revenue code, rate code, procedure code and modifier combinations
- Three different types of sessions
  - Individual
  - Individual, per diem
  - Group

Community Psychiatric Support & Treatment (CPST)

- Billed daily in 15 minute increments
- Payment is broken into various levels through the use of the procedure codes and, when applicable modifier codes, that indicate the type of staff providing the service
- No group sessions
- May only be provided off-site
- Staff transportation is billed separately as appropriate: transportation billing is done at the Member level and then is only for a single staff member, regardless of the number of persons involved in providing the service

Additional services, continued

Habilitation/Residential Support Services

- Billed daily in 15 minute increments with a limit of 12 units (3 hours) per day
- There are no group sessions for this service
- May be provided on or off-site
- Staff transportation is billed separately as appropriate: transportation billing is done at the Member level and then is only for a single staff member, regardless of the number of persons involved in providing the service

Family Support and Training (FST)

- Two different types of sessions
  - Session provided to one family
  - Session provided to two – three families

Additional services, continued

Short Term Crisis Respite

- Billed daily with a max unit of 1 per day
- Stays may be no longer than 7 days per episode, not to exceed a maximum of 21 days per year (some exceptions apply, see HCBS manual)
- May only be provided in facilities dedicated to this purpose
- Fee includes transportation, do not bill transportation separately

Intensive Crisis Respite

- Billed daily with a max unit of 1 per day
- Stays may be no longer than 7 days per episode, not to exceed a maximum of 21 days per year (some exceptions apply, see HCBS manual)
- May only be provided in facilities dedicated to this purpose
- Fee includes transportation, do not bill transportation separately

Additional services, continued

Education Support Services

- Billed daily in 1 hour units with a max units of 2 (2 hours)
- May be provided on or off-site
- Staff transportation is billed separately as appropriate: transportation billing is done at the Member level and then is only for a single staff member, regardless of the number of persons involved in providing the service

Empowerment Services, Peer Supports

- Billed daily in 15 minute units with a limit of 16 units (4 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate: transportation billing is done at the Member level and then is only for a single staff member, regardless of the number of persons involved in providing the service

Additional services, continued

Pre-Vocational Services

- Billed daily in 1 hour units with a limit of 2 units (2 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate: transportation billing is done at the Member level and then is only for a single staff member, regardless of the number of persons involved in providing the service

Transitional Employment

- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate: transportation billing is done at the Member level and then is only for a single staff member, regardless of the number of persons involved in providing the service

Additional services, continued

Intensive Supportive Employment

- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate: transportation billing is done at the Member level and then is only for a single staff member, regardless of the number of persons involved in providing the service
- Modifier is used to indicate “Complex Level of Care”

On-Going Supported Employment

- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate: transportation billing is done at the Member level and then is only for a single staff member, regardless of the number of persons involved in providing the service

Transportation

Staff transportation, non-emergency

Per mile

- Billed daily in per mile units with a limit of 60 miles for a round trip
- 0.58 cents per mile (per federal guidelines)

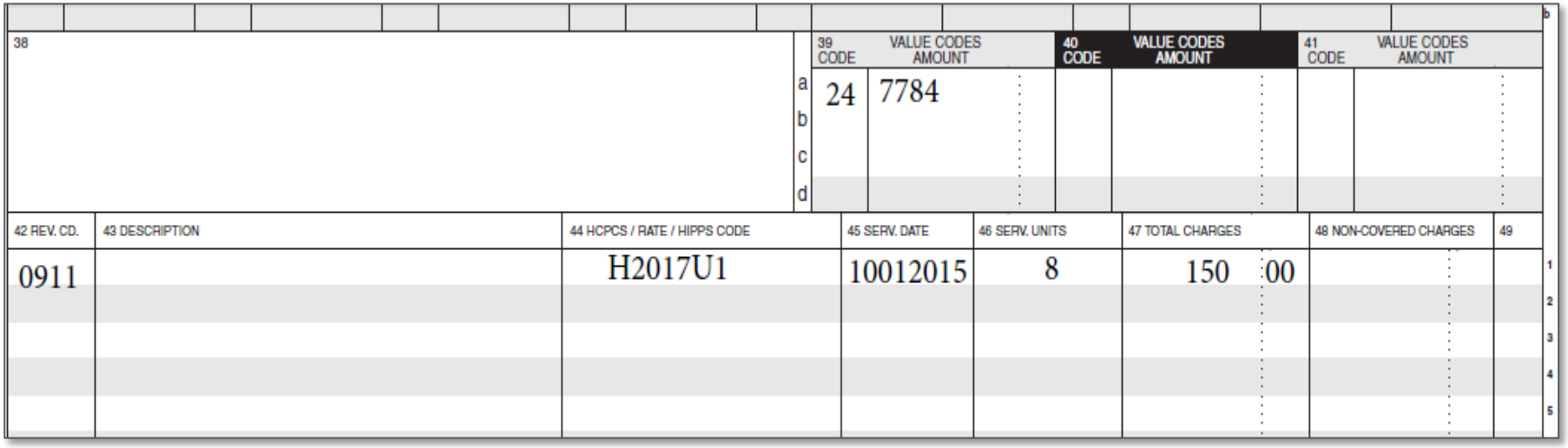
Per round trip

- Billed monthly using the first day of the month as date of service
- Each round trip counts as one unit, with a limit of 31 units per calendar month

HARP HCBS crosswalk example

Rate Code	Rate Code Description	Px Code	Px Code Description	Modi-fiers	Unit Measure	Units Limits (Claim Line Level)	Other rate codes prohibited on same day (combination edits)
7784	HARP HCBS Psychosocial Rehab - Indv - on-site	H2017	Psychosocial rehabilitation services; per 15 minutes	U1	Per 15 min	8	7785, 7789
7785	HARP HCBS Psychosocial Rehab - Indv - off-site	H2017	Psychosocial rehabilitation services; per 15 minutes	U2	Per 15 min	8	7784, 7789
7786	HARP HCBS Psychosocial Rehab - Group 2-3	H2017	Psychosocial rehabilitation services; per 15 minutes	UN or UP	Per 15 min	4	7787, 7788, 7789
7787	HARP HCBS Psychosocial Rehab - Group 4-5	H2017	Psychosocial rehabilitation services; per 15 minutes	UQ or UR	Per 15 min	4	7786, 7788, 7789
7788	HARP HCBS Psychosocial Rehab - Group 6-10	H2017	Psychosocial rehabilitation services; per 15 minutes	US	Per 15 min	4	7786, 7787, 7789

HARP HCBS example, UB-04



38		39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
	a	24	7784				
	b						
	c						
	d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
0911		H2017U1	10012015	8	150 00			1
								2
								3
								4
								5

Other rate codes prohibited on same day (combination edits): 7785 and 7789

Office of Alcoholism and Substance Abuse Services (OASAS)

Substance Use Disorder Services & Billing

OASAS Certified Substance Use Disorder (SUD) Services /Programs

- Outpatient Services
  - Setting: outpatient clinic
- Opioid Treatment Services
  - Setting: Opioid Treatment Programs (OTP)
- Intensive Outpatient Treatment
  - Setting: outpatient rehabilitation

Billing requirements

OASAS claims are reimbursed based on APG methodology

- UB-04 claim form; 837i
- Value code “24”
- Rate code
- Revenue codes
- CPT/HCPCS codes
- Procedure modifiers
- Date of service
- Service units
- OASAS Credentialed Alcoholism and Substance Abuse Counselor (CASAC) ID Number

OASAS: Important modifier reminders

- The HF modifier is requested for all OASAS claim types
  - The modifier does not impact pricing but will support data collection
- OTP programs will continue to use the KP modifier for the first medication administration visit of the service week

OASAS: outpatient rate codes, freestanding facilities

Rate codes are assigned based upon certification/program type and Setting (hospital vs. freestanding)

Title 14 NYCRR Part 822 Community/Freestanding
(Article 32 only)

- Chemical Dependence Outpatient Clinic program – rate code 1540
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1573
- Opiate treatment program – rate code 1564

<u>Medical Services</u>
Title 14 NYCRR Part 822 Community/Freestanding
(Article 32 only)

- Chemical Dependence Outpatient Program – rate code 1468
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1570
- Opiate Treatment Program – rate code 1471

OASAS: outpatient rate codes, hospital-based

Title 14 NYCRR Part 822 Hospital Based OASAS Certified Outpatient (Article 28 and Article 32)

- Chemical Dependence Outpatient Clinic program – rate code 1528
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1561
- Opiate treatment program – rate code 1567

Medical Services

Title 14 NYCRR Part 822 Hospital Based OASAS Certified Outpatient (Article 28 /Article 32)

- Chemical Dependence Outpatient Program – rate code 1552
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1558
- Opiate Treatment Program – rate code 1555

OASAS example

Table Two – Providers will enter the line level coding for SUD outpatient services including: CPT / HCPCS codes; unit (if applicable); **and, the HF modifier on each service line**

APG	OASAS Service Category Description	CPT Codes ☑	CPT Code Description	HCPCS Codes ☑	HCPCS description
318	Group Therapy 60 minute minimum	90853	Alcohol &/or Drug Services (group counseling by a clinician)	H0005	Alcohol/Substance; group counseling by a clinician
318	Group Therapy 60 minute minimum	90849	Multiple Family Group (adolescent patients) (60-90 minutes)	N/A	
322	Medication Administration & Observation No minimum time		N/A	H0033	Oral Medication, direct observation
322	Medication Administration & Observation No minimum time		N/A	H0020	Alcohol / drug services methadone admin
323	Assessment – Normative 30 minute minimum		N/A	H0001	Alcohol / drug assessment

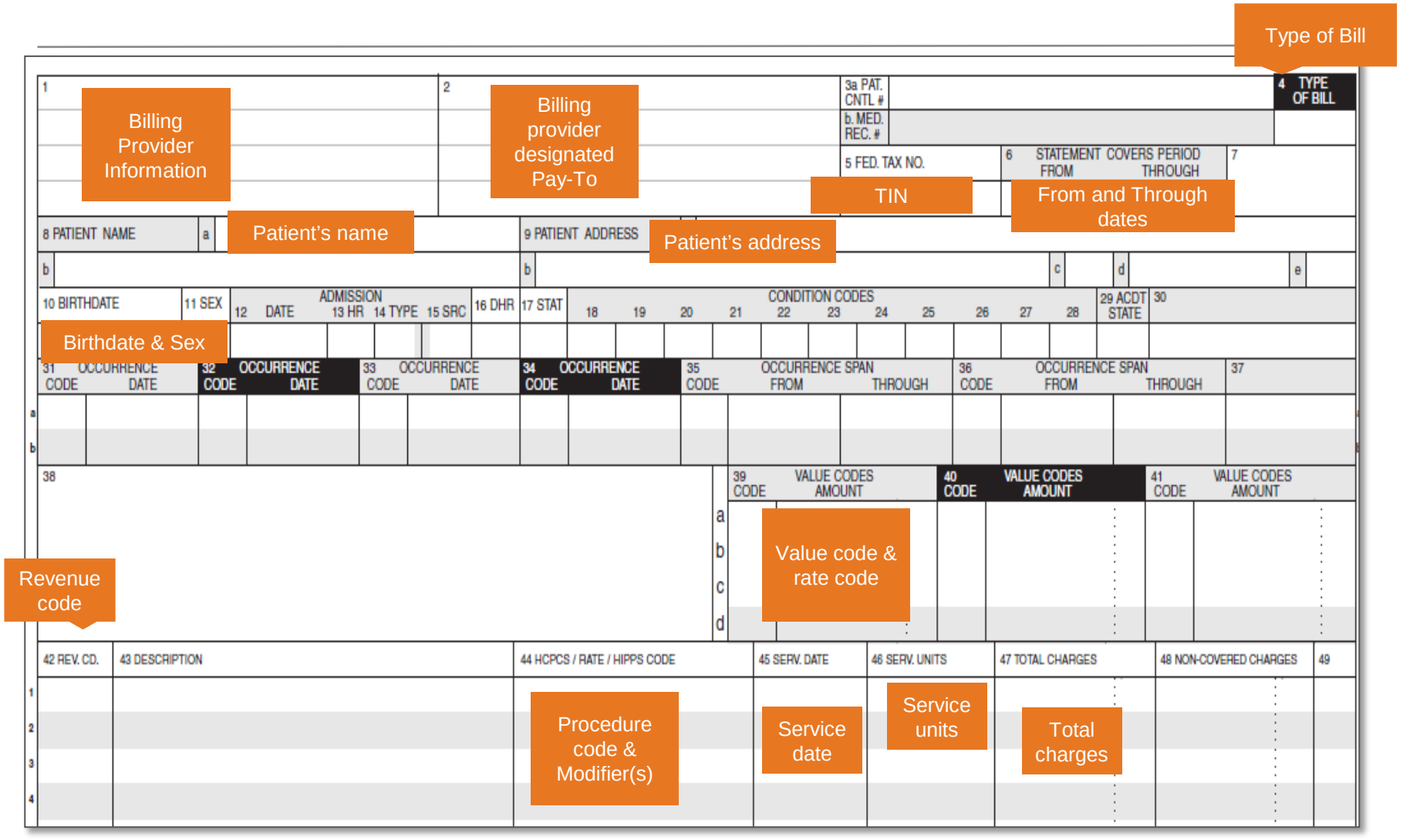
OASAS example, UB-04

38		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a	24	1540				
	b						
	c						
	d						

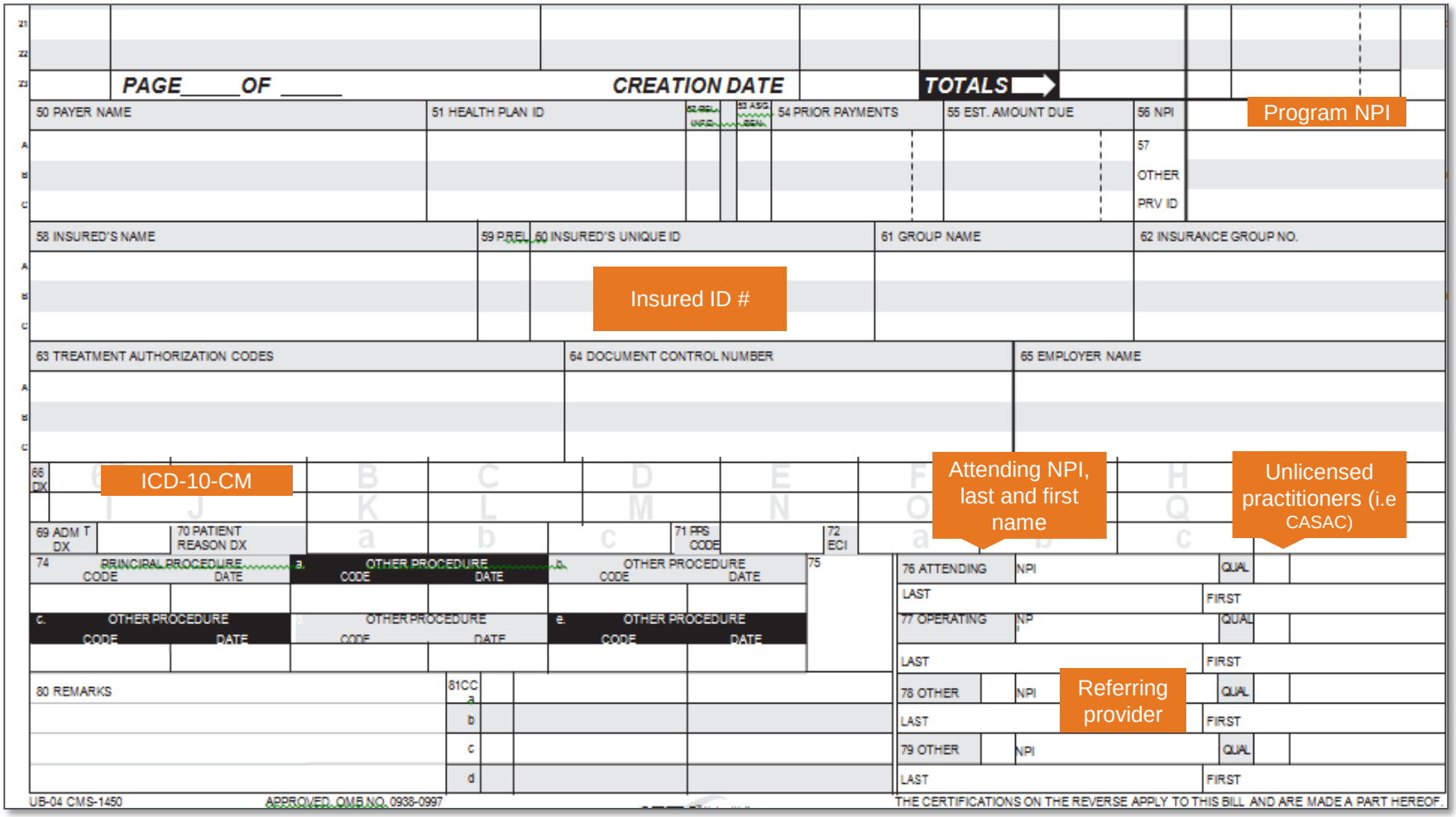
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0914		H0001HF	10012015	1	150 00		

References for slides 36 – 39:
NYS HARP/Mainstream Behavioral Health Billing & Coding Manual
Rate code – Table One: OASAS Outpatient Rate Codes
Procedure Code – Table Two: Outpatient CPT/HCPCS Coding

Required fields, UB-04, top



Required fields, UB-04, bottom



Service combinations

NYS Allowable Billing Combinations of OMH/OASAS State Plan Services and HCBS								
HCBS/State Plan Services	OMH Clinic/OLP	OASAS Clinic	OASAS Opioid Treatment Program	OMH ACT	OMH PROS	OMH IPRT/CDT	OMH Partial Hospital	OASAS Outpatient Rehab
PSR	Yes	Yes	Yes				Yes	
CPST							Yes	
Habilitation	Yes	Yes	Yes				Yes	
Family Support and Training	Yes	Yes	Yes			Yes	Yes	Yes
Education Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Peer Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Employment Services	Yes	Yes	Yes			Yes	Yes	Yes

Submission of Claims

Clean claim

A claim with no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim is considered a clean claim.

- All required fields are
  - Complete
  - Legible

All claim submissions must include:

- Member's name, Medicaid identification number and date of birth
- Provider's Federal Tax I.D. number (TIN)
- National Provider Identifier (NPI)
- A complete diagnosis (ICD-10-CM)

Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at cms.gov

Claims submission deadline

- Providers must initially submit claims within one hundred and twenty (120) days after the date of the service
- Paper clean claims will be paid within 45 days of receipt
- Electronic clean claims will be paid within 30 days of receipt
- If a provider wants to appeal a claim payment or denial, the appeal must be submitted within 90 days after receipt of the Provider Remittance Advice (PRA)

Claims submission option 1: EDI/Electronically

- Electronic Data Interchange (EDI) is an electronic-based exchange of information
- Performing claim submission electronically offers distinct benefits
  - It's fast – eliminates mail and paper processing delays
  - It's efficient – electronic processing helps catch and reduce pre-submission errors, so more claims auto-adjudicate
  - It's complete - you get feedback that your claim was received by the payer
  - It's cost-efficient - you eliminate mailing costs, the solutions are free or low-cost
- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims is 87726
- Additional information regarding EDI is available on UHCCommunityplan.com

Claims submission option 2: hardcopy

Paper claims submitted via U.S. Postal Service should be mailed to:

Optum Behavioral Health
P.O. Box 30760
Salt Lake City, UT 84130-0760

Appeals submitted via U.S. Postal Service should be mailed to:

United Healthcare Community Plan, Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

Electronic Payments & Statements (EPS)

- Faster Payments, better cash flow
- Less work, more time
- No need to change your current posting process
    - For more information call 866-842-3278, option 5
    - Or visit https://www.unitedhealthcareonline.com

Quick reminders

- Verify member eligibility
- Obtain prior authorization for those services that require it
- Use value code 24
- One rate code per claim
- Include units as applicable
- There cannot be a hyphen in your Tax Identification Number (TIN)
- NPI numbers are required
- A complete diagnosis is required
- Use the correct ICD-10-CM code set
- Home and Community Based Services require authorization except
  - Short term crisis respite up to 72 hours
  - Staff transportation

Common errors/mistakes

- Submitting claims to the wrong payer
- Member not eligible/not active with plan
- Authorization not obtained
- NPI missing or invalid
- TIN missing or invalid
- Denied for timely filing
- Wrong procedure code billed
- Duplicate claim – original paid
- Diagnosis or CPT code missing or invalid

Links to resource documents

- HARP Mainstream Billing and Coding Manual

https://www.omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf

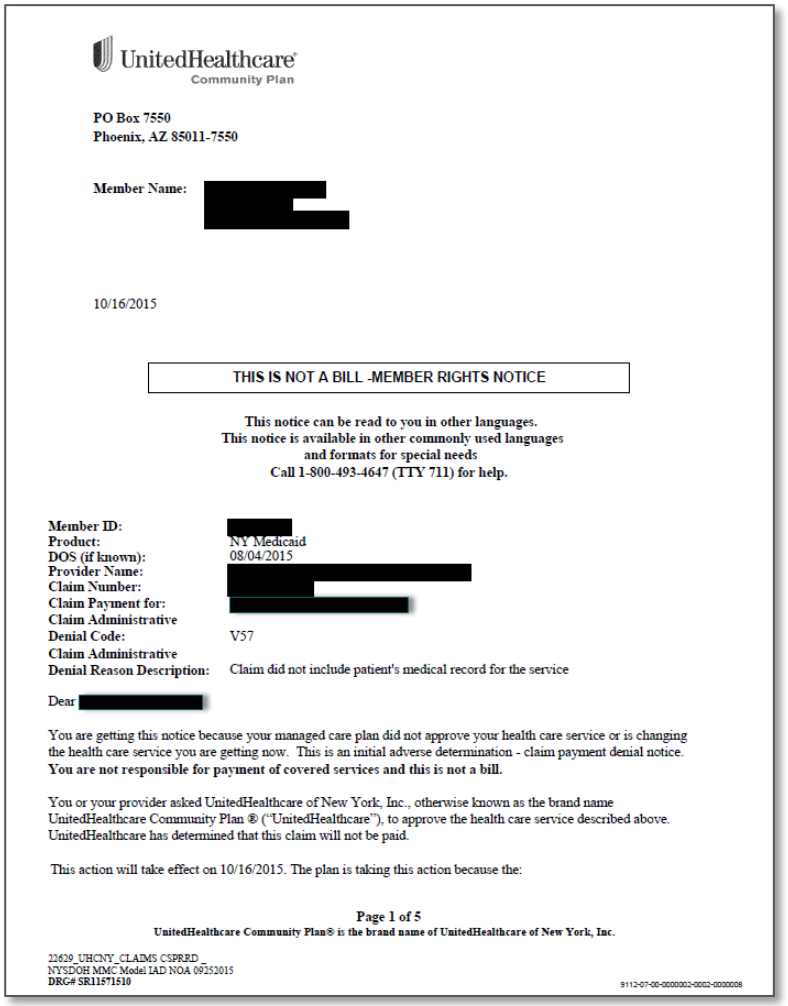
- HCBS Manual

https://www.omh.ny.gov/omhweb/News/2014/hcbs-manual.pdf

- Fee Schedule and Rate Codes

https://www.omh.ny.gov/omhweb/bho/phase2.html

Member claim notice, Medicaid



UnitedHealthcare
Community Plan

PO Box 7550
Phoenix, AZ 85011-7550

Member Name: [redacted]

10/16/2015

THIS IS NOT A BILL -MEMBER RIGHTS NOTICE

This notice can be read to you in other languages.
This notice is available in other commonly used languages and formats for special needs
Call 1-800-493-4647 (TTY 711) for help.

Member ID:	[redacted]
Product:	NY Medicaid
DOS (if known):	08/04/2015
Provider Name:	[redacted]
Claim Number:	[redacted]
Claim Payment for:	[redacted]
Claim Administrative Denial Code:	V57
Claim Administrative Denial Reason Description:	Claim did not include patient's medical record for the service

Dear [redacted]

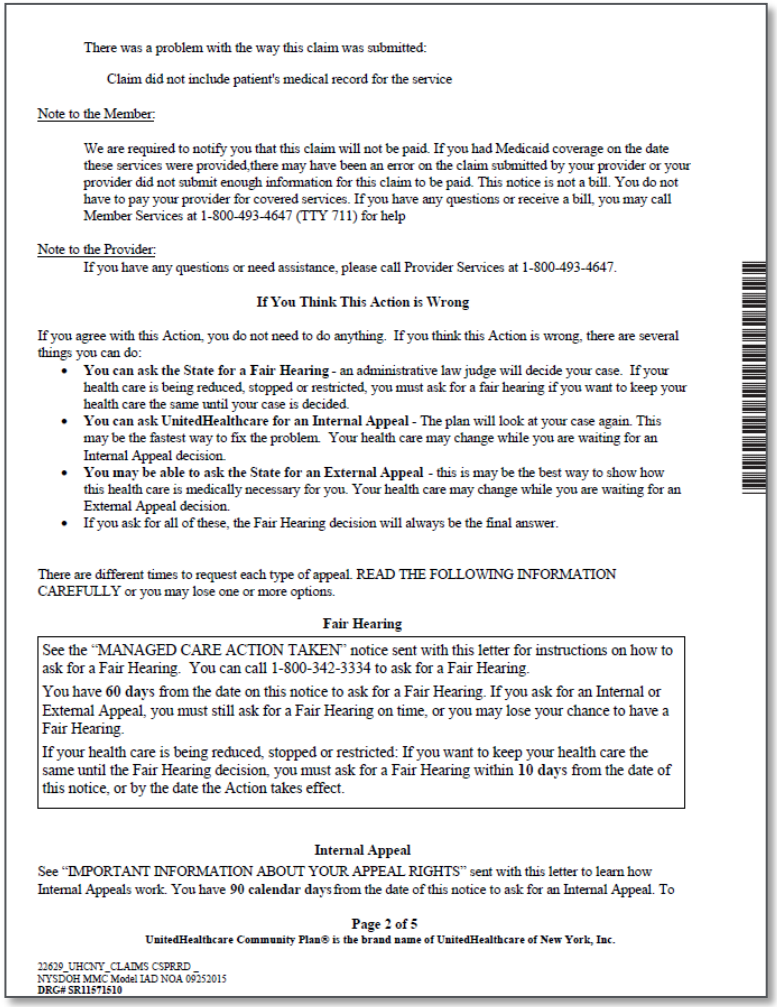
You are getting this notice because your managed care plan did not approve your health care service or is changing the health care service you are getting now. This is an initial adverse determination - claim payment denial notice. **You are not responsible for payment of covered services and this is not a bill.**

You or your provider asked UnitedHealthcare of New York, Inc., otherwise known as the brand name UnitedHealthcare Community Plan ® ("UnitedHealthcare"), to approve the health care service described above. UnitedHealthcare has determined that this claim will not be paid.

This action will take effect on 10/16/2015. The plan is taking this action because the:

Page 1 of 5
UnitedHealthcare Community Plan® is the brand name of UnitedHealthcare of New York, Inc.

22629_UHCNY_CLAIMS CSPRRD _
NYSDOH MMC Model IAD NOA 09252015
DRG# SR11571510
9112-07-00-0000002-0002-0000008



There was a problem with the way this claim was submitted:

Claim did not include patient's medical record for the service

Note to the Member:

We are required to notify you that this claim will not be paid. If you had Medicaid coverage on the date these services were provided,there may have been an error on the claim submitted by your provider or your provider did not submit enough information for this claim to be paid. This notice is not a bill. You do not have to pay your provider for covered services. If you have any questions or receive a bill, you may call Member Services at 1-800-493-4647 (TTY 711) for help

Note to the Provider:

If you have any questions or need assistance, please call Provider Services at 1-800-493-4647.

If You Think This Action is Wrong

If you agree with this Action, you do not need to do anything. If you think this Action is wrong, there are several things you can do:

- **You can ask the State for a Fair Hearing** - an administrative law judge will decide your case. If your health care is being reduced, stopped or restricted, you must ask for a fair hearing if you want to keep your health care the same until your case is decided.
- **You can ask UnitedHealthcare for an Internal Appeal** - The plan will look at your case again. This may be the fastest way to fix the problem. Your health care may change while you are waiting for an Internal Appeal decision.
- **You may be able to ask the State for an External Appeal** - this is may be the best way to show how this health care is medically necessary for you. Your health care may change while you are waiting for an External Appeal decision.
- If you ask for all of these, the Fair Hearing decision will always be the final answer.

There are different times to request each type of appeal. READ THE FOLLOWING INFORMATION CAREFULLY or you may lose one or more options.

Fair Hearing

See the "MANAGED CARE ACTION TAKEN" notice sent with this letter for instructions on how to ask for a Fair Hearing. You can call 1-800-342-3334 to ask for a Fair Hearing.

You have **60 days** from the date on this notice to ask for a Fair Hearing. If you ask for an Internal or External Appeal, you must still ask for a Fair Hearing on time, or you may lose your chance to have a Fair Hearing.

If your health care is being reduced, stopped or restricted: If you want to keep your health care the same until the Fair Hearing decision, you must ask for a Fair Hearing within **10 days** from the date of this notice, or by the date the Action takes effect.

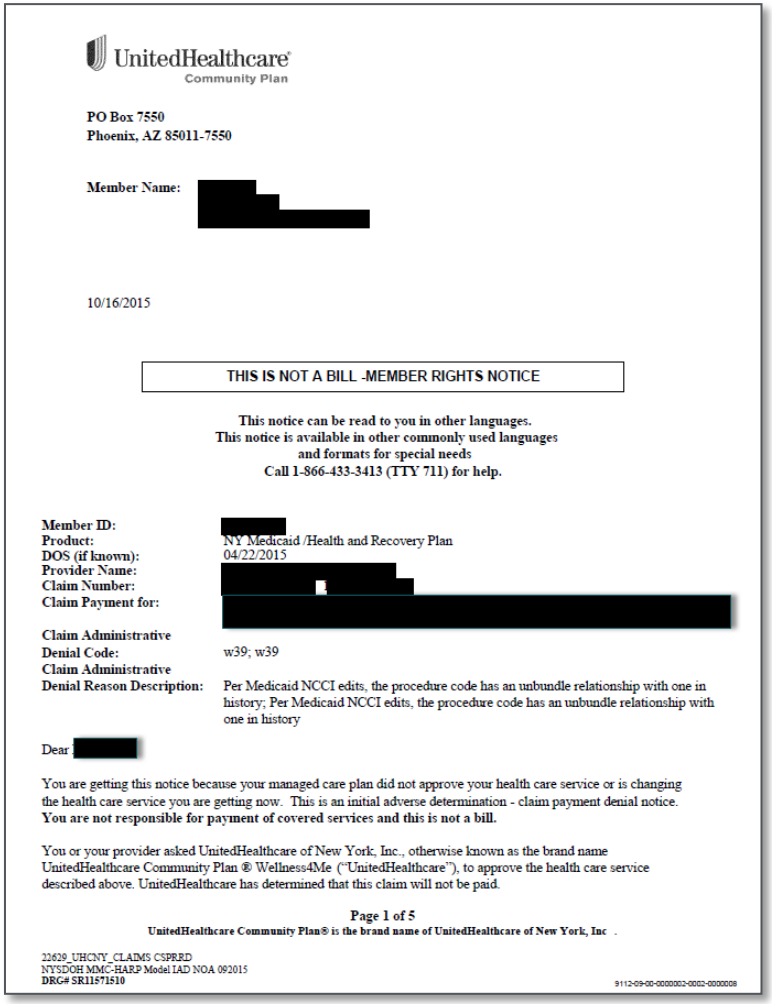
Internal Appeal

See "IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS" sent with this letter to learn how Internal Appeals work. You have **90 calendar days** from the date of this notice to ask for an Internal Appeal. To

Page 2 of 5
UnitedHealthcare Community Plan® is the brand name of UnitedHealthcare of New York, Inc.

22629_UHCNY_CLAIMS CSPRRD _
NYSDOH MMC Model IAD NOA 09252015
DRG# SR11571510

Member claim notice, Health and Recovery Plan (HARP)



UnitedHealthcare
Community Plan

PO Box 7550
Phoenix, AZ 85011-7550

Member Name: [redacted]

10/16/2015

THIS IS NOT A BILL -MEMBER RIGHTS NOTICE

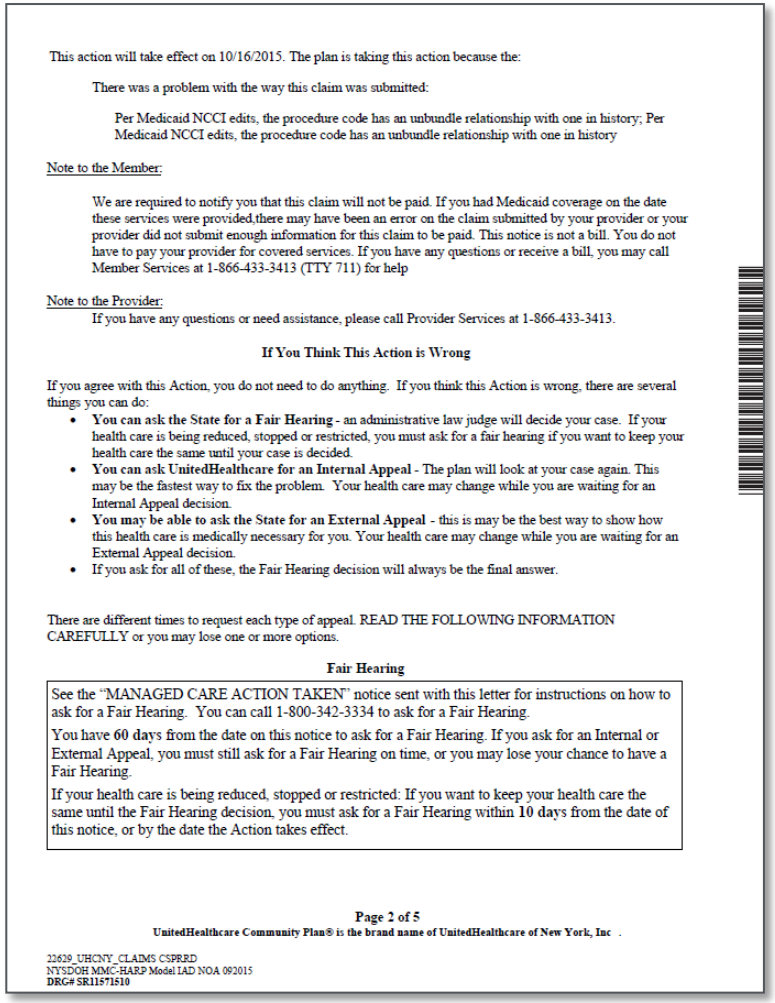
This notice can be read to you in other languages.
This notice is available in other commonly used languages and formats for special needs
Call 1-866-433-3413 (TTY 711) for help.

Member ID:	[redacted]
Product:	NY Medicaid /Health and Recovery Plan
DOS (if known):	04/22/2015
Provider Name:	[redacted]
Claim Number:	[redacted]
Claim Payment for:	[redacted]
Claim Administrative Denial Code:	w39; w39
Claim Administrative Denial Reason Description:	Per Medicaid NCCI edits, the procedure code has an unbundle relationship with one in history; Per Medicaid NCCI edits, the procedure code has an unbundle relationship with one in history

Dear [redacted]

You are getting this notice because your managed care plan did not approve your health care service or is changing the health care service you are getting now. This is an initial adverse determination - claim payment denial notice. **You are not responsible for payment of covered services and this is not a bill.**

You or your provider asked UnitedHealthcare of New York, Inc., otherwise known as the brand name UnitedHealthcare Community Plan ® Wellness4Me ("UnitedHealthcare"), to approve the health care service described above. UnitedHealthcare has determined that this claim will not be paid.



This action will take effect on 10/16/2015. The plan is taking this action because the:

There was a problem with the way this claim was submitted:

Per Medicaid NCCI edits, the procedure code has an unbundle relationship with one in history; Per Medicaid NCCI edits, the procedure code has an unbundle relationship with one in history

Note to the Member:

We are required to notify you that this claim will not be paid. If you had Medicaid coverage on the date these services were provided,there may have been an error on the claim submitted by your provider or your provider did not submit enough information for this claim to be paid. This notice is not a bill. You do not have to pay your provider for covered services. If you have any questions or receive a bill, you may call Member Services at 1-866-433-3413 (TTY 711) for help

Note to the Provider:
If you have any questions or need assistance, please call Provider Services at 1-866-433-3413.

If You Think This Action is Wrong

If you agree with this Action, you do not need to do anything. If you think this Action is wrong, there are several things you can do:

- **You can ask the State for a Fair Hearing** - an administrative law judge will decide your case. If your health care is being reduced, stopped or restricted, you must ask for a fair hearing if you want to keep your health care the same until your case is decided.
- **You can ask UnitedHealthcare for an Internal Appeal** - The plan will look at your case again. This may be the fastest way to fix the problem. Your health care may change while you are waiting for an Internal Appeal decision.
- **You may be able to ask the State for an External Appeal** - this is may be the best way to show how this health care is medically necessary for you. Your health care may change while you are waiting for an External Appeal decision.
- If you ask for all of these, the Fair Hearing decision will always be the final answer.

There are different times to request each type of appeal. READ THE FOLLOWING INFORMATION CAREFULLY or you may lose one or more options.

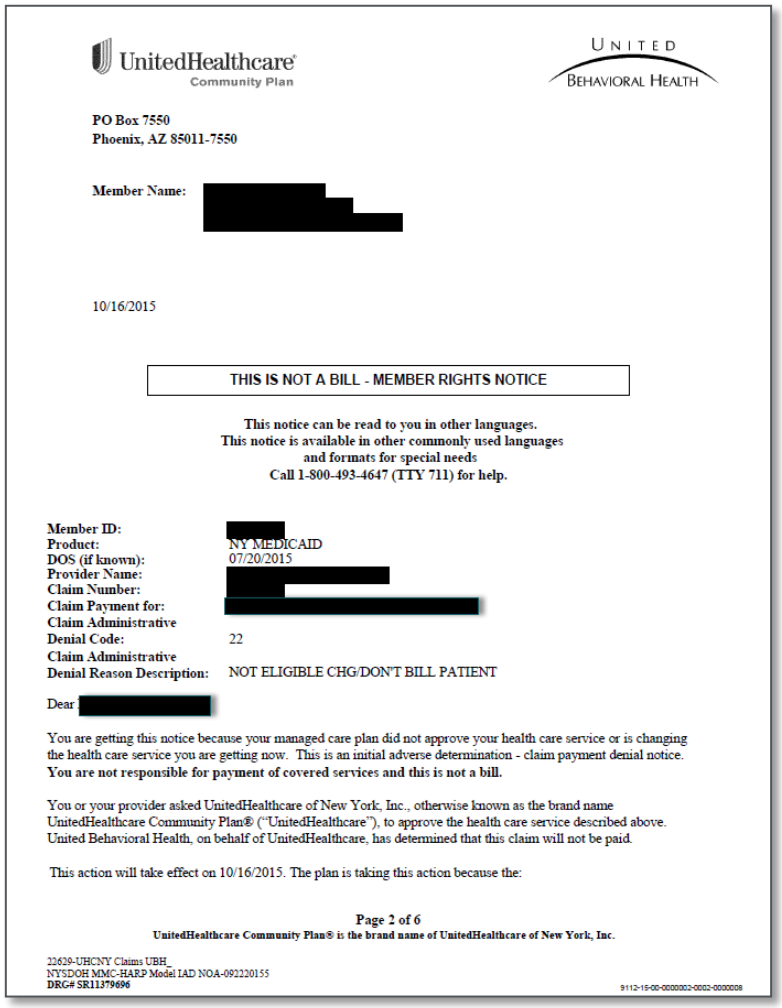
Fair Hearing

See the "MANAGED CARE ACTION TAKEN" notice sent with this letter for instructions on how to ask for a Fair Hearing. You can call 1-800-342-3334 to ask for a Fair Hearing.

You have **60 days** from the date on this notice to ask for a Fair Hearing. If you ask for an Internal or External Appeal, you must still ask for a Fair Hearing on time, or you may lose your chance to have a Fair Hearing.

If your health care is being reduced, stopped or restricted: If you want to keep your health care the same until the Fair Hearing decision, you must ask for a Fair Hearing within **10 days** from the date of this notice, or by the date the Action takes effect.

Member claim notice, Medicaid, under age 21



UnitedHealthcare Community Plan

UNITED BEHAVIORAL HEALTH

PO Box 7550
Phoenix, AZ 85011-7550

Member Name: [redacted]

10/16/2015

THIS IS NOT A BILL - MEMBER RIGHTS NOTICE

This notice can be read to you in other languages.
This notice is available in other commonly used languages and formats for special needs
Call 1-800-493-4647 (TTY 711) for help.

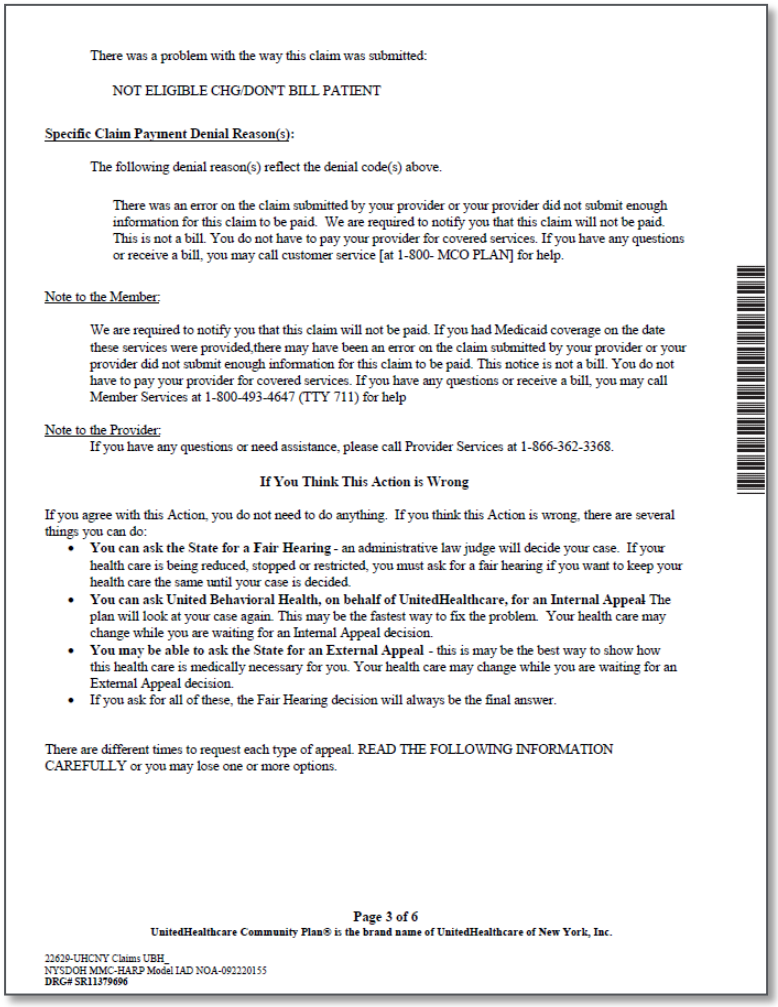
Member ID:	[redacted]
Product:	NY MEDICAID
DOS (if known):	07/20/2015
Provider Name:	[redacted]
Claim Number:	[redacted]
Claim Payment for:	[redacted]
Claim Administrative Denial Code:	22
Claim Administrative Denial Reason Description:	NOT ELIGIBLE CHG/DON'T BILL PATIENT

Dear [redacted]

You are getting this notice because your managed care plan did not approve your health care service or is changing the health care service you are getting now. This is an initial adverse determination - claim payment denial notice. **You are not responsible for payment of covered services and this is not a bill.**

You or your provider asked UnitedHealthcare of New York, Inc., otherwise known as the brand name UnitedHealthcare Community Plan® ("UnitedHealthcare"), to approve the health care service described above. United Behavioral Health, on behalf of UnitedHealthcare, has determined that this claim will not be paid.

This action will take effect on 10/16/2015. The plan is taking this action because the:



There was a problem with the way this claim was submitted:

NOT ELIGIBLE CHG/DON'T BILL PATIENT

Specific Claim Payment Denial Reason(s):

The following denial reason(s) reflect the denial code(s) above.

There was an error on the claim submitted by your provider or your provider did not submit enough information for this claim to be paid. We are required to notify you that this claim will not be paid. This is not a bill. You do not have to pay your provider for covered services. If you have any questions or receive a bill, you may call customer service [at 1-800- MCO PLAN] for help.

Note to the Member:

We are required to notify you that this claim will not be paid. If you had Medicaid coverage on the date these services were provided,there may have been an error on the claim submitted by your provider or your provider did not submit enough information for this claim to be paid. This notice is not a bill. You do not have to pay your provider for covered services. If you have any questions or receive a bill, you may call Member Services at 1-800-493-4647 (TTY 711) for help

Note to the Provider:
If you have any questions or need assistance, please call Provider Services at 1-866-362-3368.

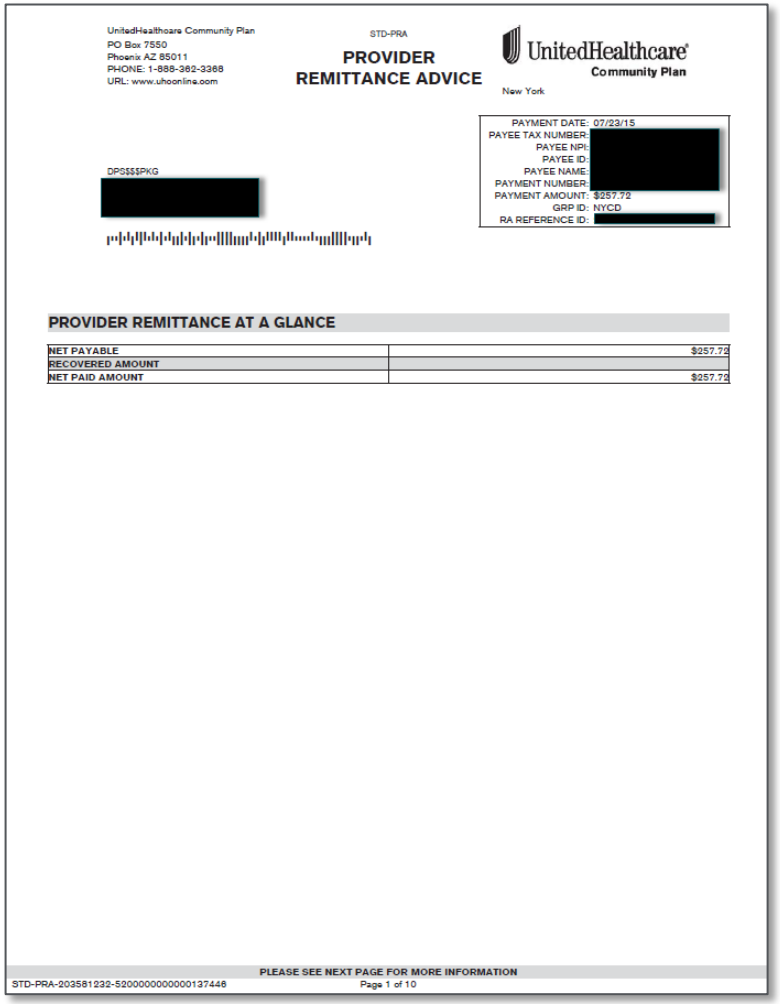
If You Think This Action is Wrong

If you agree with this Action, you do not need to do anything. If you think this Action is wrong, there are several things you can do:

- **You can ask the State for a Fair Hearing** - an administrative law judge will decide your case. If your health care is being reduced, stopped or restricted, you must ask for a fair hearing if you want to keep your health care the same until your case is decided.
- **You can ask United Behavioral Health, on behalf of UnitedHealthcare, for an Internal Appeal** The plan will look at your case again. This may be the fastest way to fix the problem. Your health care may change while you are waiting for an Internal Appeal decision.
- **You may be able to ask the State for an External Appeal** - this is may be the best way to show how this health care is medically necessary for you. Your health care may change while you are waiting for an External Appeal decision.
- If you ask for all of these, the Fair Hearing decision will always be the final answer.

There are different times to request each type of appeal. READ THE FOLLOWING INFORMATION CAREFULLY or you may lose one or more options.

Provider Remittance Advice, Medicaid and HARP



UnitedHealthcare Community Plan
PO Box 7550
Phoenix AZ 85011
PHONE: 1-888-362-3368
URL: www.uhoonline.com

STD-PRA

PROVIDER REMITTANCE ADVICE

UnitedHealthcare Community Plan
New York

PAYMENT DATE: 07/23/15
PAYEE TAX NUMBER: [redacted]
PAYEE NPI:
PAYEE ID:
PAYEE NAME:
PAYMENT NUMBER:
PAYMENT AMOUNT: $257.72
GRP ID: NYCD
RA REFERENCE ID: [redacted]

DPS$$$PKG
[redacted]

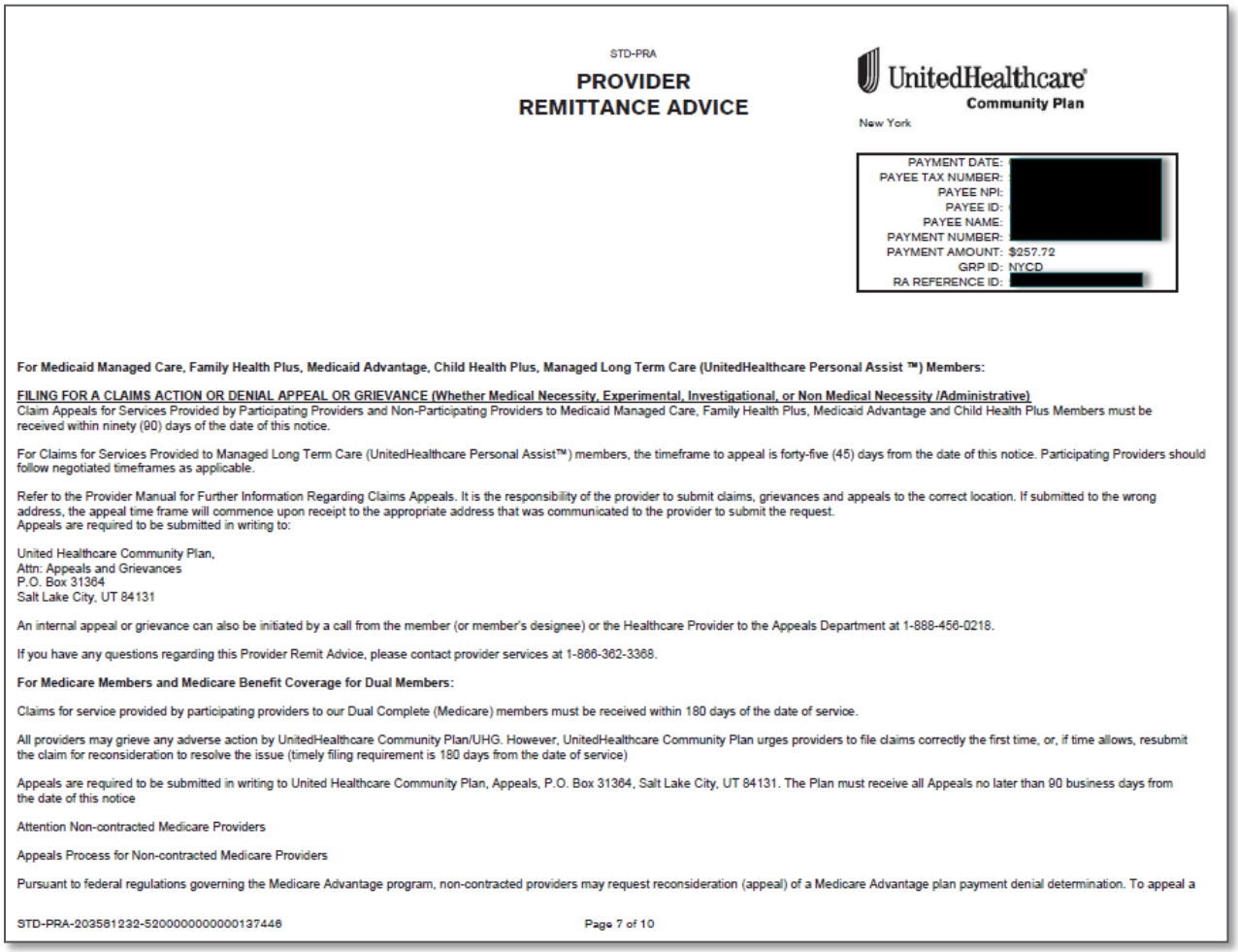
PROVIDER REMITTANCE AT A GLANCE

NET PAYABLE	$257.72
RECOVERED AMOUNT	
NET PAID AMOUNT	$257.72

PLEASE SEE NEXT PAGE FOR MORE INFORMATION

STD-PRA-203581232-5200000000000137446 Page 1 of 10

Provider Remittance Advice, Medicaid and HARP continued



STD-PRA

PROVIDER REMITTANCE ADVICE

UnitedHealthcare Community Plan

New York

PAYMENT DATE: [redacted]
PAYEE TAX NUMBER:
PAYEE NPI:
PAYEE ID:
PAYEE NAME:
PAYMENT NUMBER:
PAYMENT AMOUNT: $257.72
GRP ID: NYCD
RA REFERENCE ID:

For Medicaid Managed Care, Family Health Plus, Medicaid Advantage, Child Health Plus, Managed Long Term Care (UnitedHealthcare Personal Assist ™) Members:

FILING FOR A CLAIMS ACTION OR DENIAL APPEAL OR GRIEVANCE (Whether Medical Necessity, Experimental, Investigational, or Non Medical Necessity /Administrative)
Claim Appeals for Services Provided by Participating Providers and Non-Participating Providers to Medicaid Managed Care, Family Health Plus, Medicaid Advantage and Child Health Plus Members must be received within ninety (90) days of the date of this notice.

For Claims for Services Provided to Managed Long Term Care (UnitedHealthcare Personal Assist™) members, the timeframe to appeal is forty-five (45) days from the date of this notice. Participating Providers should follow negotiated timeframes as applicable.

Refer to the Provider Manual for Further Information Regarding Claims Appeals. It is the responsibility of the provider to submit claims, grievances and appeals to the correct location. If submitted to the wrong address, the appeal time frame will commence upon receipt to the appropriate address that was communicated to the provider to submit the request.
Appeals are required to be submitted in writing to:

United Healthcare Community Plan,
Attn: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131

An internal appeal or grievance can also be initiated by a call from the member (or member's designee) or the Healthcare Provider to the Appeals Department at 1-888-456-0218.

If you have any questions regarding this Provider Remit Advice, please contact provider services at 1-866-362-3368.

For Medicare Members and Medicare Benefit Coverage for Dual Members:

Claims for service provided by participating providers to our Dual Complete (Medicare) members must be received within 180 days of the date of service.

All providers may grieve any adverse action by UnitedHealthcare Community Plan/UHG. However, UnitedHealthcare Community Plan urges providers to file claims correctly the first time, or, if time allows, resubmit the claim for reconsideration to resolve the issue (timely filing requirement is 180 days from the date of service)

Appeals are required to be submitted in writing to United Healthcare Community Plan, Appeals, P.O. Box 31364, Salt Lake City, UT 84131. The Plan must receive all Appeals no later than 90 business days from the date of this notice

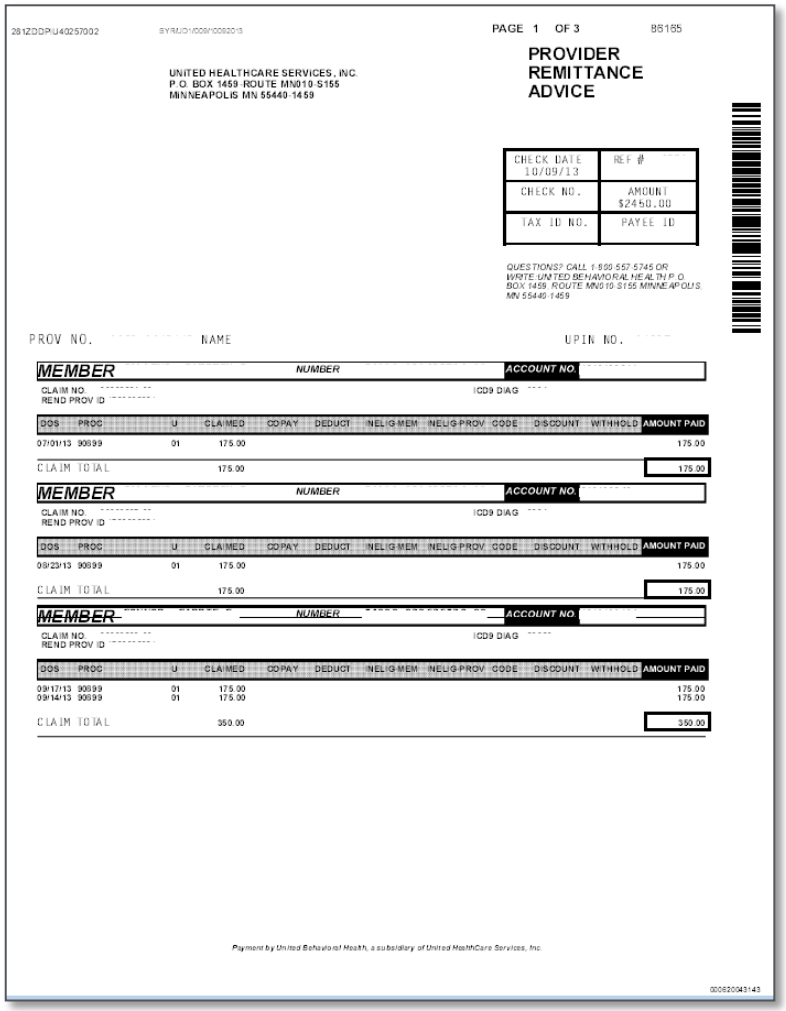
Attention Non-contracted Medicare Providers

Appeals Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination. To appeal a

STD-PRA-203581232-5200000000000137446 Page 7 of 10

Provider Remittance Advice, Medicaid, under age 21



281ZDDPU40257002 BYRUDV009R0092013 PAGE 1 OF 3 86165

UNITED HEALTHCARE SERVICES, INC.
P.O. BOX 1459-ROUTE MN010-S155
MINNEAPOLIS MN 55440-1459

PROVIDER REMITTANCE ADVICE

CHECK DATE 10/09/13	REF #
CHECK NO.	AMOUNT $2450.00
TAX ID NO.	PAYEE ID

QUESTIONS? CALL 1-866-557-5745 OR WRITE UNITED BEHAVIORAL HEALTH P.O. BOX 1459, ROUTE MN010-S155 MINNEAPOLIS, MN 55440-1459

PROV NO. NAME UPIN NO.

MEMBER NUMBER **ACCOUNT NO.**

CLAIM NO.
REND PROV ID
ICD9 DIAG

DOS	PROC	U	CLAIMED	COPAY	DEDUCT	NELIG MEM	NELIG PROV	CODE	DISCOUNT	WITHHOLD	AMOUNT PAID
07/01/13	90899	01	175.00								175.00
CLAIM TOTAL			175.00								175.00

MEMBER NUMBER **ACCOUNT NO.**

CLAIM NO.
REND PROV ID
ICD9 DIAG

DOS	PROC	U	CLAIMED	COPAY	DEDUCT	NELIG MEM	NELIG PROV	CODE	DISCOUNT	WITHHOLD	AMOUNT PAID
09/23/13	90899	01	175.00								175.00
CLAIM TOTAL			175.00								175.00

MEMBER NUMBER **ACCOUNT NO.**

CLAIM NO.
REND PROV ID
ICD9 DIAG

DOS	PROC	U	CLAIMED	COPAY	DEDUCT	NELIG MEM	NELIG PROV	CODE	DISCOUNT	WITHHOLD	AMOUNT PAID
09/17/13	90899	01	175.00								175.00
09/14/13	90899	01	175.00								175.00
CLAIM TOTAL			350.00								350.00

Payment by United Behavioral Health, a subsidiary of UnitedHealthCare Services, Inc.

00082004143

Contact us

Eunice Hudson – Provider Education Specialist

Tel: **612-642-7131**

Email: eunice.hudson@uhc.com

Svetlana (Lana) Kats – Director of Network Management for NY Public Sector

Tel: **212-898-3182**

Email: svetlana.kats@uhc.com

Contact us, continued

Behavioral Health Network Managers

Afrika Zyonne-Kumani – Manhattan, Bronx & Westchester

Tel: **518-313-4871**

Email: afrika.zyonne-kumani@uhc.com

Allandro Pierre – Queens, Nassau & Suffolk

Tel: **952-202-3839**

Email: allandro.pierre@uhc.com

Jenny Morfin – Brooklyn & Richmond

Tel: **763-321-2093**

Email: jenny.morfin@uhc.com

Contact us, continued

Gayle Parker-Wright – Network Trainer

Tel: **612-642-7307**

Email: gayle.parker-wright@uhc.com

New York Network Management – Mainstream Medicaid and Wellness4Me

77 Water Street, 14th Floor

New York, NY 10005

Email: NYHarp_ProvServices@optum.com

Phone: 877-614-0484

Fax: 877-958-7745

Thank you for attending today

Questions