



# CFP TECHNICAL ASSISTANCE BULLETIN

## CFP ENROLLMENT, DISENROLLMENT, TRANSFER AND BILLING PROCEDURES



**\*OUTSIDE NEW YORK CITY\***

**04C-08 JULY 2008**

### INTRODUCTION/BACKGROUND

Every Community Follow-up Program has the responsibility to verify that each client for whom they provide services is **Medicaid eligible** and **enrolled** in their specific program, in order to receive payment for Case Management services rendered.

Verification of client's Medicaid eligibility is done through checking one of these HIPAA compliant options: ePACES (CPU-to-CPU), Omni 3750 POS terminal, FTP Batch Option for which you currently must develop your own in-house solution. Defran is working on file formatting URS to implement FTP Batch Option for use sometime in the future. Checking clients' eligibility is one of the most crucial steps in the enrollment process, as it helps to ensure reimbursement from Medicaid for services rendered.

For a new client, if code "35" does not appear on a check of Medicaid eligibility, it means the client is **not** already enrolled with another Comprehensive Medicaid Case Management (CMCM) program, and you may enroll them in your program, assuming they have Medicaid or are Medicaid eligible. However, if a code "35" does appear for a new client, then you must follow the protocol for transfer of that client from another program to your program (see page 3).

Please remember that there are other CMCM programs besides the Community Follow-Up

Program. These CMCM programs run under the auspices of the following agencies/programs: Office of Mental Health (OMH); Office of Mental Retardation and Developmental Disabilities (OMRDD); Teenage Services Act (TASA); and Connect. The key is to determine which program best fits the client's needs. As always, communicate with the other CMCM before transferring or enrolling a client to prevent problems for the client. Many times it is best for the client to remain enrolled with another CMCM program, where they specialize in the area of greatest need for this client.

For clients already receiving services from your CFP, verification of their Medicaid status should be done on a regular basis. If the client's status includes a code "35", you can assume the client is with your program, but be aware that the client could be enrolled with another provider at any point in time. You may submit claims for them based on the date of service, which should be on or after the beginning enrollment date.

The beginning enrollment date is the date that was on the original enrollment form, which reflects a successful enrollment by the LDSS office. When checking eligibility, if the code "35" disappears for an active client, there is definitely a problem. At this point, an investigation is needed before any further submission of claims. Check to see if the client is still enrolled with your program by contacting the LDSS office. Erroneously, an

end date may have been added to the client's enrollment with your program on the Welfare Management System (WMS).

Receipt of Medicaid reimbursement for services rendered is critical for continuation of any CFP's cash flow. For that reason, specific billing guidelines must be followed carefully in order to receive payment, which is due to your program. A claim submitted to Medicaid that is incomplete or incorrect will be pended, thus delaying payment, or denied, causing the CFP to have a loss of revenues earned.

All denied claims must be investigated so corrections may be made in order to resubmit the claim to Medicaid. As a means of prevention and internal control, some type of tracking system should be established to record paid, pended, and denied claims. URS has this capability and should be used each time a Medicaid Remittance is received. If strict procedures for the billing process are in place, delay and/or denial of claims can be reduced or eliminated, while increasing collection of revenue.

## **STANDARDS AND GUIDELINES**

### **Billing procedures: enrollment and submission of claims**

#### 1) Enrollment:

\* **Before enrolling, have the client sign the CFP consent form and keep it in the client's new file.**

\* Check Medicaid eligibility for each client during the enrollment period and on the dates of service. Please note historical checking of eligibility is not acceptable by Medicaid's standards - that is why we encourage checking eligibility at intake and on a regular basis thereafter.

\* If client is an active Medicaid recipient, you must first enroll them with your program before submitting any claims.

\* If code "35" appears - check to see if client is already enrolled with your program, if not then follow directions for the transfer policy as stated below.

\* Check the enrollment form for accuracy & completeness before mailing to the LDSS office.

\* Mail two copies of the enrollment form (keep the original) to the LDSS office along with a self-addressed envelope. The enrollment form should be returned to you within 2 weeks verifying a successful enrollment of the client, or an unsuccessful enrollment with a brief explanation. However, LDSS policies will differ from one office to another. We would encourage you to establish a relationship with each LDSS office in order to rectify any enrollment issues, which may arise.

\* All returned enrollment forms must be carefully reviewed. If there are any denials, check the reason, get the correct information, and resubmit the revised enrollment form. Again, if another CFP is identified as the provider for this client, you must follow the transfer policy protocol.

\* After receipt of enrollment verification from the LDSS office, it is suggested that a program wait up to 2 weeks to submit their first claim for the new client. There is a lag period for the information to get from the Welfare Management System (WMS) to the Computer Sciences Corporation (CSC) payment system. CSC is the contracted fiscal agent for the New York State Medicaid Program. Still, services can continue to be given, because filing a claim and reimbursement may be accomplished within 90 days of enrollment. However, the date of service must be within the enrollment dates to ensure payment.

\* Keep all enrollment forms in one binder for easy access and for comparison with the Medicaid Remittances containing claim denials.

## 2) Submission of Claims:

\* Claims may be submitted to Medicaid by mail on paper, disk, tape, or sent electronically (only HIPAA compliant) by modem.

\* **After March 2005, no physical media (disk and tape) will be supported, only the electronic submission of claims.** To send claims electronically you must have an Electronic Transmitter Identification Number (ETIN). You may call CSC @ (800) 522-5518 to attain this number.

\* After March 2005, paper claims will still be accepted, but only on the new form "UB-92." See the website @ [www.emedny.org](http://www.emedny.org).

\* Paper claims are not recommended as they are considered tedious and time consuming to use. Also, it does not allow for the tracking and reporting options as found with the **URS billing software**, which is recommended by the AIDS Institute.

## 3) Paid/Pended/Denied Claims:

\* Medicaid remittance statements will be returned to you with a reimbursement check, along with the status of all claims submitted. It is imperative that all remittances are methodically reviewed to track paid, pended, and denied claims.

\* As of March 2005, Medicaid remittances will be sent one of two ways, either paper or electronic, but not both. Additionally, there will be a limit of 10,000 claims per remittance and each remittance will have a corresponding check issued.

\* Denied claims may be *resubmitted* with the correct information. Pended claims should not be resubmitted. Instead, wait until they are paid or denied. If paid, no further action is required; if denied you can then resubmit the claim after the error has been investigated and corrected.

\* For quarterly and annual reporting to the AIDS Institute, and for internal fiscal management purposes, it is essential to have accurate unduplicated totals for paid, pended, and denied claims.

## 4) Problem Solving for Denied Claims:

\* First, follow all of the guidelines above, and for the client in question check the enrollment form again to ensure there was approval for your program by Medicaid through the LDSS office. Second, check that the date of service is on or after the beginning enrollment date, but not after the end date (if any). If you still can find nothing wrong, speak with a representative from the LDSS office to see what they show for the client on their system (WMS).

\* It is recommended that someone from your program visit the LDSS office in person, so a face-to-face contact is made to establish a relationship, which will enhance communication between offices. The next time you have a question for the LDSS, you may phone the representative encountered personally for assistance.

\* If you have followed all of the correct procedures and still have significant problems, contact your program manager, or Marianne O'Grady in Albany @ (518) 486-1323.

## **Transfer of clients from one CMCM to another CMCM**

### 1) Before Transfer takes place:

\* When new clients arrive at your program you may not be aware of their enrollment with another CMCM program. That is why it is necessary to check all Medicaid numbers for Medicaid eligibility before the enrollment process is started. If you note a code "35" is already on the system for this client, do not enroll the client until the transfer process has been completed. The next step is to communicate with the current CMCM provider. It is important to understand that if

you have provided services to a client before the transfer has taken place, you may not be paid for these services. The other provider may not agree to the transfer date requested.

\* If the client wishes to change agencies have them bring a signed closure letter from the current CMCM provider, which will be sufficient documentation for the transfer. This is to be maintained in the client's record and a copy sent with the enrollment form. If that is not possible, the Program Director of the requesting CMCM program must initiate contact with the Program Director of the current CMCM program, in order to agree upon the last date of service for the client in the current program.

\* If the client is enrolled with another CFP or other CMCM provider, and cannot remember the name of that Program, the provider's name may be acquired by submitting an enrollment form to the LDSS. They will return the form to you with the provider number of the other CFP, where the client is currently enrolled. You may also be able to obtain this information by phone, saving valuable time and effort by calling the LDSS. If you are not able to get through to a person at the LDSS, you may contact your program manager, or Marianne O'Grady in Albany @ (518) 486-1323.

## 2) Transfer Process:

\* **FIRST - Both Program Directors** involved in a transfer of a client must agree on a transfer date or last date of service for the current CFP. The requesting CFP must initiate the process. They should fill out a transfer form, date & sign it, and send it to the current CFP or other CMCM provider. A transfer form clarifies the client's desire to change from one specific provider to another specific provider. This form is a formal written request for change, which all parties should retain for their records as documentation of the transfer process.

\* Make four copies of the transfer form - submit two copies to the LDSS, keep one, and

send a copy to the other provider. It is advisable to wait about 2 weeks from the date of the transfer confirmation from the LDSS before submitting the first claim. The reason for waiting is due to the lag time for information to get from the WMS to the CSC payment system.

\* Keep all transfer forms in a separate binder for easy access.

\* Remember that all *confidentiality laws* apply to the transfer process as well. You will need a consent form signed by the client before communication with another provider can take place.

\* Respect the client's right to choose another program by cooperating with the new CMCM provider in the transfer process.

## **Disenrollment**

### When a client's case is closed for any reason:

\* Fill out a disenrollment form and submit to the LDSS.

\* The disenrollment form should be placed in the closed case record along with the case closure form. Also, keep a copy of all disenrollment forms in a separate binder for easy reference if needed.

## **Additional Information for COBRA Providers**

### Preventing Denied Claims

- 1) Keep some type of internal tracking system for recertification dates of all clients enrolled with your program who are due for renewal of their Medicaid.
- 2) A team member should follow-up with each client prior to their recertification date to ensure they have an appointment with their respective Medicaid Case Worker.
- 3) If necessary, assign a staff member to accompany the client to their recertification

appointment. Ensure that the recertification date gets backdated to the previous date of service. Medicaid may be backdated up to three months.

- 4) Checking each client's Medicaid eligibility daily will provide critical and timely information about Medicaid coverage changes. Thereby, allowing staff to act quickly in order to prevent loss of Medicaid coverage.

### **SNP's – Code 20 and Code 21**

When a client is enrolled in a Special Needs Plan (SNP), a managed care plan, their Medicaid eligibility will show a code "20" for an HIV enrollee, or a code "21" for an AIDS enrollee. These codes for the SNP's managed care plans do not conflict with a code "35" CCM enrollment. If the eligibility states Managed Care "GUARANTEE," it means the client's Medicaid has lapsed and they are only entitled to the managed care plan's services. A denied claim would reflect a code "00699" where the recipient's coverage indicates capitation and claims are paid for plan services only.

### **Managed Care GUARANTEE**

Guarantee means Medicaid lapsed!!! When the client was originally enrolled with the SNP's, and their Medicaid was active, they were guaranteed 6 months of continuous enrollment with the plan, even if their Medicaid coverage lapses. However, if the specific client's Medicaid coverage lapses due to missing the recertification deadline, the word "GUARANTEE" will show on the eligibility screen. The recipient cannot access carved out services such as pharmacy and COBRA case management, only the SNP's services. Please work with the client and the SNP plan to reestablish FULL Medicaid eligibility, so efforts are not duplicated.

### **PLEASE NOTE**

#### **LDSS AND MAP OFFICES WILL NOT:**

CHANGE INFORMATION ON ANY FORMS SUBMITTED TO THEM.

ENROLL OR DISENROLL ANY CLIENT WITH CONFLICTING OR MISSING INFORMATION.

HANDLE ANY CLAIMS.

#### **LDSS AND MAP OFFICES WILL:**

***ENROLL, DISENROLL, AND TRANSFER CLIENTS ON THE WELFARE MANAGEMENT SYSTEM***

#### **Important & Useful Web Sties for COBRA Providers:**

[www.emedny.org](http://www.emedny.org)

[www.nyhipaadesk.com](http://www.nyhipaadesk.com)

[www.ursny.org](http://www.ursny.org)

[www.defran.com](http://www.defran.com)

[www.cobracm.org](http://www.cobracm.org)

[www.health.state.ny.us/nysdoh/mancare/omm/main](http://www.health.state.ny.us/nysdoh/mancare/omm/main)