NEW YORK STATE MEDICAID PROGRAM

MANAGED CARE MANUAL: STOP-LOSS POLICY AND PROCEDURE

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Section I – Purpose Statement

The purpose of this document is to assist participating managed care organizations in understanding and complying with the New York State Medicaid (NYS-Medicaid) requirements and expectations for billing.

The guide addresses the following subjects:

- Stop-Loss

This document is customized for managed care providers as an instructional as well as a reference tool.

Section II – Stop-loss Policy and Procedure

Background

Stop-Loss is a type of reinsurance, or risk protection, offered by NYS to Medicaid managed care plans, which is intended to limit the plan's liability for individual enrollees. The state agrees to pay for costs incurred by the plan that exceed a certain threshold amount. Stop-Loss payments are in addition to the monthly capitation payment made by NYS for each enrollee.

Plans providing comprehensive benefits under the state's 1115 waiver to all eligible Medicaid enrollees may elect to purchase reinsurance from NYS to cover the following:

General Inpatient Reinsurance

- For mainstream Medicaid managed care plans, hospital inpatient claims with a uniform threshold of $100,000 as of 1/1/2010 ($50,000 through 12/31/09) per enrollee per calendar year are the liability of the plans. For amounts paid in excess of $100,000 as of 1/1/2010 ($50,000 through 12/31/09) a plan will receive 80% reimbursement for the remainder of the calendar year up to $250,000. For amounts in excess of $250,000, the plan will receive 100% reimbursement.

  Reimbursement for hospital inpatient claims is based on the lower of any negotiated rate between the plan and hospital, or the Medicaid calculated rate. Effective 1/1/96, the calculated Medicaid rate is the published alternate Medicaid payment rate that excludes the cost of Graduate Medical Education (GME), as well as the Recruitment and Retention component implemented in 2002. Hospitals bill NYS directly for the GME and Recruitment and Retention components for hospital admissions of Medicaid managed care enrollees.

- HIV Special Need Plans (SNPs) may purchase similar reinsurance from NYS. The reinsurance covers 85% of hospital inpatient expenses exceeding $100,000 per enrollee per calendar year, up to $300,000. Above $300,000, 100% of expenses are covered.

Note the SDOH Bureau of Managed Care Financing will maintain a list of plans that purchase the above reinsurance from NYS.

Mental Health and Alcohol and Substance Abuse Reinsurance

Effective January 1, 2009, NYS reinsurance is no longer available for outpatient mental health visits (Stop-Loss rate code 2294).

All mainstream Medicaid and HIV SNP plans are eligible for the following inpatient mental health and substance abuse Stop-Loss coverage for enrollees *not* categorized as SSI or SSI related at the time of service, regardless of whether plans purchase general inpatient reinsurance from NYS:

- Medically necessary and clinically appropriate Medicaid reimbursable inpatient mental health services and/or inpatient alcohol and substance abuse treatment services (chemical dependency) in excess of thirty (30) days during a calendar year at the lower of the plan's negotiated inpatient rate or the Medicaid rate of payment. Note inpatient services provided by Article 31 facilities known as Institutions of Mental Disease (IMDs) to enrollees aged 21 through 64 are limited to 30 consecutive days per episode or up to 60 inpatient days per year; Stop-Loss coverage for IMD services began January 1, 2004.

The Stop-Loss insurance does not apply to mental health/substance abuse services subcontracted to a managed behavioral health care company or to inpatient detoxification services provided in Article 28 hospitals.

Note: Mental health and substance abuse services provided to members who were not classified as SSI or SSI related *at the time of service* are still covered under the stop-loss program even if the enrollee is retroactively classified SSI or SSI related and the retroactive period includes dates when such services were provided. However in this instance, plans are required to submit appropriate documentation (for example the enrollee roster showing the Aid Category at the time of service) along with the attestation and other supporting documentation for the Stop-Loss claim.

Residential Health Care Facility (Nursing Home) Reinsurance

Effective January 1, 2005 for all Mainstream Medicaid managed care plans and April 1, 2005 for HIV SNPs, reinsurance will pay for medically necessary Residential Health Care Facility (RHCF) inpatient stays in excess of 60 days per enrollee per calendar year for enrollees who are not in permanent placement status. As with Mental Health and Alcohol and Substance abuse services, the plan is responsible for paying claims to its providers and may bill NYS for visits in excess of the threshold. Stop-Loss payments will be made at the lesser of the plan's negotiated rate with the RCHF or the Medicaid daily rate.

Rate codes to be used to submit Stop-Loss Claims:

For Stop-Loss claims, plans should use the rate codes listed below as applicable.

Stop-Loss Rate Codes

Rate Code	Type of Stop-Loss	Applicability By Type of Managed Care Plan
2295	➢> 30 Inpatient Mental Health/Alcohol and Substance Abuse Days (see IMD limitation)	Mainstream Medicaid, HIV SNP
2296	➢Inpatient Expenditures > $100,000 Per Enrollee Per Year, 15% Coinsurance For Payments Up To $300,000	HIV SNP
2297	➢> 60 RHCF Inpatient (Nursing Home) Days	Mainstream Medicaid, HIV SNP
2299*	➢Inpatient Expenditures >$100,000 as of 1/1/10 ($50,000 through 12/31/09) Per Enrollee Per Year, 20% Coinsurance For Payments Up To $250,000	Mainstream Medicaid

*** Effective January 1, 2010, the inpatient Expenditure threshold was changed from $50,000 to $100,000.**

Note: There is no reinsurance coverage of any type provided by NYS for the Family Health Plus, Child Health Plus, Managed Long Term Care and Medicare/Medicaid Advantage Dual Eligible programs, which should be covered by private reinsurance.

Process for Submission of Stop-Loss Claims

Managed care plans are not required to submit documentation with their requests for Stop-Loss payments from NYS. Instead, plans provide summary information and submit this with an attestation that proper and complete documentation is on file and subject to State audit. Should documentation be found to be incomplete or inaccurate upon audit, plans are subject to recoupment of part or all of the Stop-Loss claims paid by the Office of the Medicaid Inspector General. Forms to be used to submit Stop-Loss claims are attached to this document.

The following describes the basic steps in submission of Stop-Loss claims, the verification, editing and payment process, and the scope and process for audits of claims.

All attestations and supporting documentation for claims should be submitted separately to the following address:

NYS Department of Health
Division of Managed Care
Bureau of Managed Care Financing
Corning Tower, Rm 1970
Albany, New York 12237

- The second part of a Stop-Loss claim must be submitted to the Fiscal Agent in your normal claim submission mode, either on paper (UB04) or an approved HIPAA compliant electronic format (837I).
- It is suggested that the plan submit only **one** Stop-Loss claim per enrollee for **all** hospital stays (not one per stay) in any given benefit year (calendar year). Only claims that have been paid to the provider of service may be submitted for Stop-Loss reimbursement.
- Verify all inpatient stay sheets are completely and accurately filled out, including the two digit code for "disposition status" and include sufficient information to support billing the given AP-DRG or APR-DRG.
- If submitting inpatient stays paid as high cost outliers, indicate those stays for review on the claim cover sheet and submit appropriate supporting documentation to SDOH.
- Verify date(s) of Medicaid eligibility and Managed care enrollment.
- The date of service on the claim form may equal the claim submission date but cannot be later than the last date for which the enrollee was covered by the Plan.
- Submit a claim using a date of service that is both within the Medicaid eligibility period and the Plan enrollment period and is less than two years from the calendar date the claim is being submitted to the Fiscal Agent.
- Claims will be held to a two-year limit for proper submission of Health (SDOH).

- If the last day of the enrollee's plan enrollment is over two years from the Stop-Loss submission date, the last date of plan enrollment should be used as the date of service. Claims of this type should be submitted to the Fiscal Agent and a copy of the claim, remittance showing the edit 01292 denial, the attestation and all original attachments should be sent to the address noted below. The Plan also must submit an explanation of the circumstances causing the delay in billing.

Revised Protocol for Stop-Loss claims denied for edit 01292

Edit 01292: Date of service two years prior to date received.

All claims for Stop-Loss payment must be finally submitted to the SDOH, and be payable, within two years from the close of the benefit year in order to be valid and enforceable against the SDOH.

Edit 01292 is an eMedNY system edit that will result in an automatic claim denial. The eMedNY system will deny all claims that fail to meet the two year filing deadline, including Stop-Loss; there are no exceptions to this edit. Claims that are received two years or more after the last effective date of service for claim submission will be denied. Plans may request a review of the timely filing edit in an effort to obtain a waiver that is issued by the Two Year Unit. In order for a claim to qualify for a waiver, the following guidelines must be met:

The SDOH will *only* consider Stop-Loss claims **over two years from the close of the benefit year** for payment if the provider can produce documentation verifying that the cause of the delay was the result of agency error or a Court-ordered payment. If a Provider believes that claims denied for edit 01292 are payable due to one of these reasons, they may request a review. These claims must be submitted within 90 days of the date on the remittance advice with supporting documentation including the attestation and all original attachments to:

New York State Department of Health
Two Year Claim Review
150 Broadway, Suite 6E
Albany, New York 12204-2736

* Please note that for Two Year Waiver purposes **the close of the benefit year** is defined as the earliest of:

- the last day of the enrollee's plan enrollment, or
- the last day of the enrollee's Medicaid eligibility, or
- the enrollee's date of death, or
- the last calendar day of the benefit year.

Initial Verification of Stop-Loss Submission

- A minimum number of basic edits will be performed upon submission of a Stop-Loss claim, prior to payment, such as verification that the identified enrollee was in fact enrolled in the plan during the specific time period indicated by dates of service.

- Prepayment Review will verify that:

- The Stop-Loss threshold is applicable for that plan and time period, based on executed contracts/amendments between the plan and local district, any plan co-payments and applicable third party payments have been properly deducted from the amount of the claims, and the calculation of amount owed is mathematically correct based on the information on the claim summary;
- Only services covered by the applicable Stop-Loss policy are included in the claim;
- All data requested is supplied;
- Inpatient claims are reimbursed at the lower of the plan's negotiated hospital rate or the Medicaid calculated rate. Where the calculated Medicaid rate is lower than the amount indicated on the claim submission, the lower amount will be the basis for claim payment.
- The close of the benefit year is not greater than two years from the date submitted; or the provider has clearly demonstrated that the delay was the result of errors by the Department, the local social services districts, or other agents of the Department; or the court has ordered the Department to make payment.

Determination of Threshold

All claims paid by the plan appropriate for the type of Stop-Loss are to be used when determining whether the threshold has been reached. For newborns, the $100,000 as of 1/1/10 ($50,000 through 12/31/09; $100,000 for HIV SNPs) inpatient threshold would include the hospital inpatient birth cost if paid by the plan, plus any additional inpatient hospital costs incurred in that calendar year. Note that the plan is responsible for ensuring that it has made every effort to identify and collect any third party payments PRIOR to submission of a Stop-Loss claim for reimbursement. All Stop-Loss claims must be paid only for expenditures after recovery offsets, as provided for in the attestation statement.

Payment of Claims

Upon completion of this initial verification review, valid claims will be processed for adjudication by the fiscal agent. Reimbursement amounts may be adjusted during the prepayment review to reflect the calculated Medicaid inpatient rate or to delete claim amounts that do not contain all information required on the summary form. Plans will be notified of any changes in the amounts reimbursed on the REMIT statement. A plan may submit revised information for an inpatient claim if it would support a re-determination of the Medicaid calculated hospital payment, following Medicaid billing procedures for adjustments of paid claims. Denied claims with revised supporting documentation must be submitted as a new claim.

Audit Process

Audits will focus on the verification of claims submitted through examination of appropriate and complete documentation maintained by the plan. Documentation must be available on-site at a single central location of the plan. An audit team may request that complete documentation be

made available to them via mail or for on-site verification within 2 business days of prior written notice.

Required Audit Documentation

Documentation should consist of an itemized claim from a provider that indicates the enrollee name, date of service, patient diagnoses and procedures, provider name and identification number, and the dollar amount of the claim. The plan must be able to provide evidence, via canceled check or similar documentation, of amount and date of payment to provider.

Verification of the appropriateness of amounts paid must also be available on-site at the same location. This would include copies of executed provider contracts containing explicit payment terms and schedules where applicable. Hospital documentation would normally consist of a UB04 or 837I that reflects all information shown on the Stop-Loss claim summary.

For claims paid to non-participating providers or to providers where no contract exists (other than inpatient) the plan must be able to document through actual paid claims that it routinely reimburses such providers on that basis (i.e., Medicare fee schedule, 80% of charges, etc.).

Any claims paid that appear in excess of amounts routinely paid by the plan for same or similar services will be denied or adjusted downward.

There must also be evidence that any third party coverage was properly identified, that reasonable collection efforts were made prior to submission of the Stop-Loss claim, and that any third party payments received were offset against the amount requested under the Medicaid Stop-Loss program.

To the extent that documentation is lacking for particular dates of service, the amount of Stop-Loss paid relating to these services may be recouped.

Mental Health and Substance Abuse Stop-Loss

Under both the voluntary and mandatory programs, managed care plans must provide all medically necessary mental health and substance abuse services with no limits except for inpatient IMD services explained below. However, plans can receive reimbursement for days and visits incurred for these services in excess of certain threshold amounts per enrollee, per calendar year, as follows:

- For enrollees not categorized as SSI and SSI related at the time of service with more than a total combined of 30 days of inpatient mental health services during the calendar year in a voluntary, municipal, licensed proprietary hospital or inpatient alcohol and substance abuse treatment services in a free-standing alcohol residential treatment program or voluntary, municipal, licensed or proprietary hospital during a calendar year, the plan will be compensated for medically necessary and clinically appropriate Medicaid services provided in excess of this amount, on the basis of the lower of the plan's negotiated hospital or Medicaid rate of payment.

IMD Services

Note: Beginning January 1, 2004, the excess 30 day inpatient mental health/alcohol and substance abuse Stop-Loss coverage has been expanded to include inpatient services provided to adult enrollees in freestanding Article 31 facilities known as Institutions for Mental Disease up to the IMD coverage limitations under the Medicaid managed care program. Under the federal special terms and conditions in New York's 1115 waiver, both plan determined and court ordered inpatient stays in IMDs for enrollees aged 21 through 64 are limited to 30 consecutive days per episode or up to 60 inpatient days per year. The IMD inpatient days should be included in the accumulation of mental health, alcohol and substance abuse days under the Stop-Loss program and are reimbursable once the 30 day Stop-Loss threshold is reached only for those days within the above stated benefit limits for IMD services.

Enrollees aged 21 through 64 who require IMD inpatient services of more than 30 consecutive days per episode or 60 inpatient days per year should be disenrolled when these thresholds are reached.

Residential Health Care Facility (Nursing Home) Stop-Loss

Medicaid managed care plans are required to provide the full range of NYS Medicaid RHCF benefits to its enrollees. RHCFs are facilities licensed under Article 28 of the NYS Public Health Law and include AIDS nursing facilities. Covered health care services include the following: medical supervision, 24 hour per day nursing care, assistance with the activities of daily living, physical therapy, and speech language pathology services and other services as specified in the NYS Health Code for Residential Health Care Services and AIDS facilities. Plans are responsible for all medically necessary RHCF inpatient stays for health plan members who are not in permanent placement status as determined by the Local Department of Special Services (LDSS) - or Human Resources Administration in NYC - and may bill NYS under the Stop-Loss program for all days exceeding 60 per member per calendar year using the procedures described in the beginning of this section.

Permanent Placement Status

Permanent placement status is determined when the LDSS determines the individual is not expected to return home based on medical evidence affirming the individual's need for permanent placement. The plan should disenroll individuals determined by LDSS to be in permanent placement status; the effective day of disenrollment will be the first day of the month following LDSS classification of the RHCF stay as permanent.

Plans are also responsible for paying for RHCF respite days authorized by the plan and bed reservation days, which are included in the Stop-Loss coverage for total days exceeding 60 per member per calendar year. Respite days are paid at the full Medicaid rate while bed reservation days are paid at a lower, reserved bed rate.

Respite Days

Respite days, or scheduled short term nursing care, are days during which an enrollee who is normally cared for in the community resides in an RHCF for purposes of providing respite for an

enrollee's caregiver(s), while providing nursing home care for the individual. The plan should only approve Respite days pursuant to a physicians order when the patient needs nursing home level of care. To be reimbursable under the Stop-Loss program, the plan must submit an attestation the patient requires nursing home level of care and the respite is pursuant to a physicians order. Scheduled short term nursing care admissions are generally pre-arranged for 1-30 days per stay and no more than 42 days per year except in extraordinary circumstances.

Bed Reservation Days

Bed reservation days, or bedhold days, are days during which a bed is held for an enrollee who was admitted to a hospital with the expectation the enrollee would return to the nursing home in fifteen days or less. To be reimbursable for Stop-Loss, the plan must attest the enrollee has been a resident of the nursing home for at least 30 days since the date of initial admission (at least one of which was paid by Medicaid or by a Medicaid managed care plan), and the nursing home has a vacancy rate of no more than 5% on the first day the enrollee is hospitalized or on leave of absence. If the enrollee doesn't return to the nursing home by the 15th day but it is expected that a return within 20 days is possible, the nursing home may request an additional 5 reserved bed days subject to the approval of the MCO. The MCO must submit an attestation the 5 additional days were requested by the nursing home and approved by the MCO.

Section III – Common Problems in Stop-Loss Billing and How to Avoid Them

It is important to note that while SDOH will make every effort to assist plans to receive payment for the Stop-Loss claims they submit, some common problems on the part of the managed care plans or their representatives may delay or even result in denial of payment. These problems are preventable. As mentioned earlier in this Section, all relevant criteria (e.g. thresholds, copayments and other Third Party insurance payments) must be documented.

After all the appropriate fields have been completed on the **Stop-Loss Claim Form UB04** or in the **Electronic HIPAA 837I Format**, the claims should be submitted to the Fiscal Agent while the supporting documents, including a properly signed, notarized and dated attestation form, should be sent directly to SDOH.

The following **Q and A** have been put together in order to prevent instances of delay and denial as a result of common mistakes:

Questions	**Answers**
➢ **What date of service should be used on the claim for instances where the enrollee has either lost Medicaid eligibility or disenrolled from the plan?**	✓ Verify date(s) of Medicaid eligibility and managed care enrollment. Then, submit claims using a date of service that is both within the Medicaid eligibility and the Plan enrollment period. ✓ If an enrollee is no longer enrolled in the plan, submit claims using the last date of plan enrollment as the date of service.
➢ **What do I do if I incur additional expenses during the year, after a Stop-Loss claim has been paid**	✓ When submitting adjustments to a prior Stop-Loss claim: ✓ Include the claim reference number (TCN) of the most recent paid claim within the same benefit year on the adjusted claim. ✓ The amount of payment being requested must be the total amount due, including the previous payment. ✓ Submit the claim to the Fiscal Agent, and send supporting documents to SDOH. (Claims that have been previously denied cannot be adjusted.) ✓ Claims previously paid by NYS are eligible for adjustments within a six year window from the date of service.
➢ **If I am paid reinsurance on a claim that is later determined to have been linked to a duplicate CIN recovery by SDOH, do I repay the Stop-Loss reinsurance as well as the premium?**	✓ If it has been determined that the Plan received inappropriate payments for a consumer who had duplicate benefits, the Plan should return any payments for the overlap period that SDOH has indentified.

➢**Why are claims being rejected for lack of supporting documentation?**

- ✓ The reports of service and other supporting forms are necessary in order to determine the dollar amount to be paid by SDOH.
- ✓ Stop-Loss claims submitted without an annual attestation on file, the inpatient stay and itemized service forms will not be approved.
- ✓ In order to avoid this problem, you must submit all the above forms with all claims to SDOH.

➢**What common mistakes can I avoid when submitting documentation to SDOH?**

- ✓ When submitting inpatient and itemized service forms, make sure that you denote correctly:
- ✓ the name of the eligible enrollee
- ✓ date of service
- ✓ enrollee's Medicaid identification number
- ✓ date of birth
- ✓ male or female
- ✓ any other pertinent information.

➢**What if I need more information and assistance?**

If you need further assistance, please contact:

NYS Department of Health
Division of Managed Care
Bureau of Managed Care Financing
Corning Tower, Rm 1970
Albany, NY 12237
518 474-5050

➢**Why are my claims denied or paid less than the amount I expected?**

Commonly, plans submit ineligible bills such as claims incurred while the consumer was FHP enrolled. Also, plans are encouraged to group their claims prior to submission to better identify expected reimbursement.

Section IV – Appendix

STOP-LOSS FORMS

In order to submit documentation for Stop-Loss claims to the SDOH, the following required forms are attached:

Annual attestation statement:

- ✓ Annual attestations are sent to managed care plans each year in the beginning of December.
- ✓ A plan must have an annual signed, notarized original attestation on file in order to submit claims to Stop-Loss.

Claim Cover Sheet:

- ✓ Be sure the benefit year on the cover sheet matches the supporting documentation.
- ✓ The Net Amount of Stop-Loss Payment Due on the cover sheet should match the amount due on the claim submitted to the Fiscal Agent.
- ✓ Claims requesting high cost outlier review for stays included in the claim should be itemized on the cover sheet. A copy of a UB04 or screen print documenting total hospital charges for a high cost outlier stay must accompany the claim.
- ✓ A claim cover sheet must accompany all claims submitted to SDOH.

Inpatient Stay Sheet for Rate Code 2296 (SNPS)/2299 (Mainstream):

Three inpatient stay sheets attached
(1) AP-DRG for stays through 11/30/09
(2) APR-DRG- for stays between 12/1/09- 12/31/09
(3) APR-DRG for stays on or after 1/1/10

- ✓ The diagnoses and procedure codes provided on this form must regroup to AP-DRG/APR-DRG listed or the stay may be adjusted downward or denied.
- ✓ All claims requesting high cost outlier consideration must be accompanied by a copy of the total hospital charges.

Inpatient Mental Health Stay Sheet for Rate Code 2295:

- ✓ Inpatient mental health coverage- Rate Code 2295 for Stop-Loss does not apply to inpatient stays for detoxification in Article 28 hospitals. In this setting, detox is considered a medical issue, not mental health.

Inpatient Residential Health Care Facility Stay Sheet for Rate Code 2297

- ✓ Be sure to include the admitting diagnosis on the inpatient stay sheet.
- ✓ Rate code 2297 does not include home health care or day care.

Print Form

ANNUAL STOP-LOSS ATTESTATION STATEMENT

For the period of January 1, 2011 through December 31, 2011

STATE OF NEW YORK **COUNTY OF** _____:

I, _____, have the authority to make this attestation
NAME & POSITION

legally binding on behalf of

_____, [hereinafter "Plan"]. On behalf of the
PLAN NAME & MEDICAID MMIS #

Plan, I hereby attest to the

State of New York that satisfactory documentation, including proof of payment to providers for all claims for enrollees submitted for Stop-Loss re-insurance submission, will be provided upon request or pursuant to any audit or other inquiry conducted by the State of New York to verify the appropriateness of the Stop-Loss payment.

Documentation

Documentation includes, but is not limited to: date(s) of service; verification that recipient was enrolled in the plan during all dates of service, all applicable medical records, patient diagnoses, service provider name(s) and identification number(s); and, proof of amount(s) actually paid to the service provider(s). Such amount(s) must be consistent with the terms of the contract between the local social services district and the plan or in the absence of specific contract term, then based on specific plan/provider contract terms, or shown to be the amount customarily paid by the plan for the service(s). Documentation must be accompanied by a cover sheet that details the submitted claim and the amounts used to calculate the claim total. The cover sheet must include: Plan Name and Medicaid ID # Enrollee Name - Enrollee ID# Benefit Year Applicable Stop-Loss Threshold Total Amount Over Threshold Less: Any Applicable Plan Liability and Third-party Payments. Please specify (e.g., co-payments and other insurance coverage): Net Amount of Stop-Loss Payment Due Plan Documentation requirements may be modified upon notice to the Plan and any other specific information that is or should be in the possession of the Plan must be provided upon request of the State of New York.

The Plan acknowledges that New York State has the right to recoup part or all of any monies paid by the State of New York to the Plan for Stop-Loss claims for inappropriate, incomplete or inaccurate or unavailable supporting documentation. The Plan ensures that all senior staff having pertinent responsibilities have read and are familiar with the New York State Medicaid Program's Managed Care Manual: Stop-Loss Policy and Procedure and all revisions thereto. The Plan can provide an appropriate staff member to attest that all claims are made in full compliance with the pertinent provisions of the Manual and revisions.

On behalf of the Plan, I attest that I have taken all reasonable measures to ensure that all information provided on this statement and the accompanying form(s) is true, accurate and complete to the best of my knowledge and that no material fact has been omitted. Furthermore, I attest that the Plan is due a Stop-Loss payment for identified enrollees and that this applies to all Stop-Loss claims submitted electronically or on paper, using the Plan's or my own NPI or Medicaid provider identification number. This attestation remains in effect and applies to all claims unless expressly superseded by another properly executed attestation statement.

Signature _____ Print/Type Name _____

Title _____ Name of Plan _____

State of _____ County of _____

On this _____ day of _____, 20____, before me personally came _____,

to me know and known to me to the individual described in and who executed the foregoing instrument, and (s)he acknowledge to me that (s)he executed the same.

[SEAL] NOTARY PUBLIC _____

STOP-LOSS CLAIM COVER SHEET

Plan Name _____**Plan Medicaid Identification #** _____

Date _____ **Plan Stop-Loss Contact**_____

Contact's e-mail _____ **Contact's Telephone #** _____

Enrollee Name _____

Enrollee Client Identification Number (CIN) _____

Transaction Control Number (TCN)_____
(if submitting an adjustment)

Benefit Year _____

Applicable Stop-Loss Threshold _____

Total Amount Over Threshold_____

Less: Any Applicable Plan Liability And Third Party Payments. Please Specify (e.g. Co-payments and other Insurance coverage) _____

Net Amount of Stop-Loss Payment Due Plan _____

□ **High Cost Outlier**
Please check box if packet contains stays to be reviewed as High Cost Outlier

Number of stays to be reviewed as HCO _____

Dates of service for each HCO outlier stay _____

- **All inpatient stays designated as HCO must be accompanied by documentation of the total charges** for that stay (ex: UB-04, screen print of electronic transactions).

INPATIENT STAY – RATE CODE 2299/2296 (SNPS) through 11/30/09

Managed Care Plan Name _____ Plan Medicaid ID#_____

Hospital Name_____
(Use hospital's full name)

Out of State Hospital Address_____

Hospital MMIS ID#_____ NPI #_____
Medicaid MMIS # (National Provider Identification Number)

Patient Name_____ Patient CIN #_____

Admit Date_____ Discharge Date_____ LOS_____
(Number of Days in Stay)

Acute Care Days_____ ALC Days_____
(Total Number of Acute Care Days) (Total Number of ALC Days)

Date of Birth_____ Age____ Sex_____ Birth weight _____grams
(Birth wt must be included for newborns up to 28 days old or DRG 602-641)

Disposition (status) __ __ Admitting Diagnosis_ _ _ . _ _ Total Hospital Charges_____
(Must be a 2 digit code)

ICD-9 DIAGNOSIS(ES)

Principal _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _
Other _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _
Other _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _

ICD-9 Procedure(s) (if applicable)

Principal _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _
Other _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _
Other _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _	**Other** _ _ _ . _ _

DRG_____ Amount Paid by Plan_____

SIW_____ Trim points: Low_____High_____Upstate_____Downstate_____
Average Length of Stay Average Length of Stay

APR Rates used (check appropriate rate used): _____Excluded - Public Health Law §2807-c(33)
Applies to inpatient stays on or after 7/1/08

_____Included – Public Health Law §2807-c(33)

Claim calculated as: **(Where applicable, please list all calculations used to determine amount due from Stop Loss. Ex.: inlier & long stay; short stay & transfer. Stop Loss reimbursement is always the lower of all calculated totals.)**

☐ Inlier ☐ Long Stay ☐ Short Stay ☐ Transfer (02 Disposition) ☐ Exempt Unit
(Medical Rehab)

☐ Top 20 DRG ☐ High Cost Outlier ** ☐ Other_____
** (include copy of total hospital charges) Please specify (Ex. Burn Unit)

Last saved by NYSDOH OHIP – 4/09

INPATIENT STAY – RATE CODE 2299/2296 (SNPS) FOR DISCHARGE DATES BETWEEN 12/1/09 – 12/31/09

Managed Care Plan Name _____ Plan Medicaid ID#_____

Hospital Name_____
(Use hospital's full name)

Out of State Hospital Address_____

Hospital MMIS ID#_____ NPI #_____
Medicaid MMIS #) (National Provider Identification Number)

Patient Name_____ Patient CIN #_____

Admit Date_____ Discharge Date_____ LOS_____
(Number of Days in Stay)

Acute Care Days_____ ALC Days_____
(Total Number of Acute Care Days) (Total Number of ALC Days)

Date of Birth_____ Age_____ Sex_____ Birth weight _____
(Birth wt must be included for newborns up to 28 days old)

Disposition (status) __ __ Admitting Diagnosis_ _ _ ._ _
(Must be a 2 digit code)

ICD-9 DIAGNOSIS(ES)_____

	ICD-9 CODE	POA	ICD-9 CODE	POA	ICD-9 CODE	POA	ICD-9 CODE	POA	ICD-9 CODE	POA
Principal										
Other										
Other										
Other										
Other										

ICD-9 Procedure(s) (if applicable)_____

	CPT CODE	CPT CODE	CPT CODE	CPT CODE	CPT CODE
Principal					
Other					
Other					
Other					
Other					

APR - DRG_____ SEVERITY LEVEL_____ SIW_____

AVERAGE LENGTH OF STAY (ALOS)_____

Hospital Charge_____ Amount Paid by Plan_____

FACILITY RATE: Default case payment rate_____ Contract case payment rate_____

Claim calculated as:

☐ Inlier ☐ Transfer ☐ Exempt Unit
(Psych, Alcohol/Substance abuse, Medical Rehab)

☐ High Cost Outlier ** ☐ Other_____
** (include copy of hospital charges)

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INPATIENT STAY – RATE CODE 2299/2296 (SNPS) FOR ADMISSION DATES on or after 01/01/2010

Managed Care Plan Name _____ Plan Medicaid ID#_____

Hospital Name_____
(Use hospital's full name)

Out of State Hospital Address_____

Hospital MMIS ID#_____ NPI #_____
(Medicaid MMIS #) (National Provider Identification Number)

Patient Name_____ Patient CIN #_____

Admit Date_____ Discharge Date_____ LOS_____
(Number of Days in Stay)

Acute Care Days_____ ALC Days_____
(Total Number of Acute Care Days) (Total Number of ALC Days)

Date of Birth_____ Age_____ Sex_____ Birth weight _____
(Birth wt must be included for newborns up to 28 days old)

Disposition (status) ___ ___ Admitting Diagnosis_ _ _ ._ _
(Must be a 2 digit code)

ICD-9 DIAGNOSIS(ES)_____

	ICD-9 CODE	POA	ICD-9 CODE	POA	ICD-9 CODE	POA	ICD-9 CODE	POA	ICD-9 CODE	POA
Principal										
Other										
Other										
Other										
Other										

ICD-9 Procedure(s) (if applicable)_____

	CPT CODE	CPT CODE	CPT CODE	CPT CODE	CPT CODE
Principal					
Other					
Other					
Other					
Other					

APR - DRG_____ SEVERITY LEVEL_____ SIW_____

AVERAGE LENGTH OF STAY (ALOS)_____

Hospital Charge_____ Amount Paid by Plan_____

Claim calculated as:

☐ Inlier ☐ Transfer ☐ Exempt Unit
(Psych, Alcohol/Substance abuse, Medical Rehab)

☐ High Cost Outlier ** ☐ Other_____
** (include copy of hospital charges)

Last saved by NYSDOH OHIP - 6/10

MENTAL HEALTH INPATIENT STAY – RATE CODE 2295

Managed Care Plan Name _____ Plan Medicaid ID#_____

Hospital Name_____
(Use hospital's full name)

Out of State Hospital Address_____

Hospital MMIS ID#_____ NPI #_____
Medicaid MMIS # (National Provider Identification Number)

Patient Name_____ Patient CIN #_____

Admit Date_____ Discharge Date_____ LOS_____
(Number of Days in Stay)

Date of Birth_____ Age_____ Sex_____ ALC Days_____
(Total Number of ALC Days)

Disposition (status) __ __ Admitting Diagnosis_ _ _ ._ _
(Must be a 2 digit code)

ICD-9 DIAGNOSIS(ES) _____

Principal _ _ _ . _ _ **Other** _ _ _ . _ _ **Other** _ _ _ . _ _ **Other** _ _ _ . _ _

Other _ _ _ . _ _ **Other** _ _ _ . _ _ **Other** _ _ _ . _ _ **Other** _ _ _ . _ _

ICD-9 Procedure(s) (if applicable) _____

Principal _ _ _ . _ _ **Other** _ _ _ . _ _ **Other** _ _ _ . _ _ **Other** _ _ _ . _ _

Other _ _ _ . _ _ **Other** _ _ _ . _ _ **Other** _ _ _ . _ _ **Other** _ _ _ . _ _

DRG _____ Amount Paid by Plan_____
(if applicable)

Inpatient Mental Health Claim calculated as:

☐ DRG ☐Per Diem ☐Exempt Unit (specify type, i.e., - Psych, Alcohol/Substance Abuse

_____

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Residential Health Care Facility (RHCF) Stay
RATE CODE 2297

Managed Care Plan Name _____ Plan Medicaid ID#_____

RHCF Name_____

RHCF Medicaid ID#_____ NPI #_____

Patient Name_____ Recipient #_____

Patient's Placement Status in RHCF (check one): Permanent_____ Temporary_____

Admit Date_____ Discharge Date_____Admitting Diagnosis_____

Disposition (status)__ __ Length of Stay (LOS) in RHCF _____

Total Amount Paid _____ Per Diem Rate Paid by Plan _____

RHCF's Medicaid Per Diem Rate _____

Number of Prior Authorized Respite Days included in LOS above _____
(if included requires additional attestation)

Number of Prior Authorized Bed Reservation Days included in LOS above _____
(if included requires additional attestation)

Complete following if Bed Reservation Days included:

Dates of Bed Reservation Days_____

RHCF Occupancy Rate on Date of First Bed Reservation Day_____%

Per Diem Rate Paid to RHCF for Bed Reservation Days_____

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Available Resources for Assistance

CSC Support - eMedNY

- ✓ CSC PROVIDER SERVICES
(800) 343-9000 (OPTION 3, THEN OPTION 4)

- ✓ www.eMedNY.org
This site contains a wealth of information. There are links to the monthly Medicaid Update, NYHIPAADESK, and recommended Vendors for software issues.

- ✓ TECHNICAL SUPPORT
Provides information on e-Paces and for batch submissions for eligibility checks through eXchange. Large numbers of eligibility transactions, referred to as 270 transactions are available.

- ✓ REMIT STATEMENTS
Make sure you have access to the REMIT statements that are sent to every Plan. These statements contain valuable information about the status of your claims.

NYS DOH HEALTH COMMERCE SYSTEM

- ✓ Secure website for the NYS Department of Health.

- ✓ Contains valuable information concerning rates, SIW's, Letters to Health Plans, links to nursing home rates, calculation sheets, a secure e-mail, a complete list of all health care facilities in New York, including OPCERT numbers.

- ✓ Requires an account and password in order to assess the site.

- ✓ Call 866 529-1890 to set up an account.

The Stop-Loss Unit is currently testing an electronic submission system for claim documentation (cover sheet, inpatient stay sheets, etc.) This system will be ready for trials in 2011.