NEW YORK STATE MEDICAID PROGRAM

MANAGED CARE MANUAL: STOP LOSS POLICY AND PROCEDURES

TABLE OF CONTENTS

Section I – Purpose Statement

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

The guide addresses the following subjects:

- Stop Loss

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

Section II – Stop Loss Policy and Procedures

Background

Stop Loss is a type of reinsurance, or risk protection, offered by New York State Department of Health (NYS DOH) to Medicaid managed care plans, which is intended to limit the plan's liability for individual members. The NYS DOH 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 DOH for each member.

Plans providing comprehensive benefits under the State's 1115 waiver to all eligible Medicaid members may elect to purchase reinsurance from NYS DOH to cover the following based on their benefit package:

General Inpatient Reinsurance

- For Mainstream Medicaid and HARP managed care plans, hospital inpatient claims (which includes Article 28 with LTACH federal designation) with a uniform threshold of $200,000 as of 1/1/2022, ($100,000 from 1/1/2010-12/31/2021) per member per calendar year are the liability of the plans. For amounts paid in excess of $200,000 a plan will receive 80% reimbursement for the remainder of the calendar year, up to $350,000 as of 1/1/2022 ($250,000 through 12/31/21). For amounts in excess of $350,000, 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 1/1/1996, 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 DOH directly for the GME and Recruitment and Retention components for hospital admissions of Medicaid Managed Care members.

- HIV Special Need Plans (SNPs) may purchase similar reinsurance from NYS DOH. The reinsurance covers 85% of hospital inpatient expenses exceeding $200,000 as of 1/1/2022 ($100,000 through 12/31/2021) per member per calendar year, up to $400,000 as of 1/1/2022 ($300,000 through 12/31/2021). For amounts in excess of $400,000, the plan will receive 100% reimbursement.

Note: The Division of Health Plan Contracting and Oversight (DHPCO) will maintain a list of plans that purchase the above reinsurance from the New York State Department of Health

The NYS DOH Stop Loss Unit transitioned from paper claim processing to electronic file submissions and processing in 2011. Files are submitted in a .txt format through the NYS DOH secure server. Detailed information can be found in the section titled *Process for Submission of Stop Loss Claims.*

Mental Health (MH) and Alcohol and Substance Abuse Reinsurance

All Mainstream Medicaid, HARP, and HIV SNP plans are eligible for the following inpatient mental health and substance abuse Stop Loss coverage for members in their benefit package.

Note: Prior to 10/01/2015 (NYC), SSI or SSI related categorization at the time of service, regardless of whether plans purchase general inpatient reinsurance from NYS DOH, were excluded from Stop Loss coverage.

- **Prior** to 10/01/2015 (NYC) & 07/01/2016 (all other areas in NYS), medically necessary and clinically appropriate Medicaid 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, were reimbursed at the lower of the plan's negotiated inpatient rate or the Medicaid rate of payment.

Under both the voluntary and mandatory programs, managed care plans must provide all medically necessary mental health and substance abuse services with no limits. However, plans can receive reimbursement for days and visits incurred for these services in excess of certain threshold amounts per member, per episodic stay* 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.

Inpatient mental health coverage for Stop Loss does not apply to inpatient stays for detoxification in Article 28 hospitals. In this setting, detox (ICD 10 PCS Code HZ2ZZZZ) is considered a medical issue, not mental health, and must be submitted under the General Inpatient Rate Code 2299.

Effective 10/01/2015 (NYC) & Effective 07/01/2016 (all other areas in NYS):

The date of 01/01/2016 is utilized for consistent processing purposes.

Year 1 - Mainstream MCOs and HARPs will be responsible for:

- 100% of the cost of the first 45 days for each psychiatric inpatient stay
- 50% of the cost of psychiatric inpatient stays for days 46 through 60. The NYS DOH will reimburse the MCOs the other 50% of the approved cost for each of these stays
- The NYS DOH will reimburse MCOs 100% of the approved cost for inpatient stays in excess of 60 days (day 61 and beyond)

Year 2 - Mainstream MCOs and HARPs will be responsible for:

- 100% of the cost of the first 60 days of each psychiatric inpatient stay
- 50% of the cost for days 61 through 100. The NYS DOH will reimburse the MCOs the other 50% of the approved cost for each of these stays
- The NYS DOH will reimburse the MCOs 100% of the approved cost for inpatient stays in excess of 100 days (day 101 and beyond)

Year 3 (and thereafter) - Mainstream MCOs and HARPs will be responsible for:

- 100% of the cost up to and including 100 days for each psychiatric inpatient stay
- The NYS DOH will reimburse the MCOs 100% of the approved cost for inpatient stays in excess of 100 days (day 101 and beyond)

Note: Prior to 10/01/2015 (NYC) & 07/01/2016 (all other areas in NYS), 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 member is retroactively classified SSI or SSI related, and the retroactive period includes dates when such services were provided.

*Where a member is transferred from/to a psychiatric facility or unit designated as such within the hospital, as indicated by Patient Status (Disposition Codes) 02 or 65, it will be considered a consecutive, single episodic stay and the total days applied toward the one threshold.

Residential Health Care Facility (Nursing Home) Reinsurance (RHCF)

Effective January 1, 2005, through December 31, 2021, for all Mainstream Medicaid Managed Care plans and April 1, 2005, through December 31, 2021, for HIV SNPs, reinsurance will pay for medically necessary Residential Health Care Facility (RHCF) inpatient stays in excess of 60 days per member, per calendar year, for members who are not in permanent placement status, as covered in their benefit package. As with Mental Health, Alcohol, and Substance abuse services, the plan is responsible for paying claims to its providers and may bill NYS DOH for visits in excess of the threshold. Stop Loss payments will be made at the lesser of the plan's negotiated rate with the RHCF or the Medicaid daily rate. Effective 1/1/2022, there is no reinsurance for Residential Health Care Facility (RHCF) inpatient stays.

The rates can be found at the following location:

Nursing Home Rates
https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/index.htm

Medicaid Managed Care plans are required to provide the full range of NYS Medicaid RHCF benefits to its members. 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 hours 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 Social 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 following sections.

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 the LDSS to be in permanent placement status; the effective day of disenrollment will be the first day of the month following the 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 a member who is normally cared for in the community resides in a RHCF for purposes of providing respite for a member's caregiver(s), while providing nursing home care for the individual. The plan should only approve Respite days pursuant to a physician's order when the patient needs nursing home level of care. To be reimbursable under the Stop Loss program, the plan must submit an attestation that the patient requires nursing home level care and the respite is pursuant to a physician's 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 bed hold days, are days during which a bed is held for a member who was admitted to a hospital with the expectation the member would return to the nursing home in fifteen days or less. To be reimbursable for Stop Loss, the plan must attest the member 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 member is hospitalized or on leave of absence. If the member 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.

Transition of Nursing Home Populations and Benefits to Medicaid Managed Care (MMC)

Effective February 1, 2015, Phase I of the transition of nursing home populations and benefits to Medicaid Managed Care began for the NYC counties of Bronx, Kings, New York, Queens and Richmond. All eligible recipients age 21 years and over in need of Long Term/Custodial Placement are required to enroll in MMCP or MLTC. Current custodial care beneficiaries in a skilled nursing facility prior to February 1, 2015 will remain FFS and will not be required to enroll in a plan. As of April 1, 2015, Phase II of the transition began including Nassau, Suffolk and Westchester counties. The rest of the counties followed July 1, 2015.

All MMC members must have a Primary Care Physician.

Restriction/Exception (R/E) codes are entered into Welfare Management System (WMS) to identify the type of long-term placement for managed care members or trigger the enrollment

process for members new to Medicaid or Managed Care. The R/E codes will appear on plan rosters; ePACES will reflect this information and will drive MC premium rate payment.

For more information see:
http://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-01-22_nh_transition.pdf
https://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-08-18_nh_transition.pdf

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	➢> 45 (HARP Year 1) Inpatient Mental Health/Alcohol and Substance Abuse Days	Mainstream Medicaid, HARP, HIV SNP
2296	➢Inpatient Expenditures > $200,000 as of 1/1/22 ($100,000 1/1/10-12/31/21) Per Member Per Year, 15% Coinsurance for Payments Up to $400,000 as of 1/1/22 ($300,000 1/1/10-12/31/21)	HIV SNP
2297	➢> 60 RHCF Inpatient (Nursing Home) Days through 12/31/2021. Note: There is no Stop Loss coverage for RHCF effective 1/1/2022.	Mainstream Medicaid, HARP, HIV SNP
2299	➢Inpatient Expenditures >$200,000 as of 1/1/22 ($100,000 1/1/10-12/31/21) Per Member Per Year, 20% Coinsurance for Payments Up to $350,000 ($250,000 1/1/10-12/31/21)	Mainstream Medicaid, HARP

- **Effective January 1, 2022, the Inpatient Expenditure threshold was changed from $100,000 to $200,000 (from January 1, 2010-December 31, 2021, the Expenditure threshold was $100,000).**

Note: There is no reinsurance coverage of any type provided by NYS DOH 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 must identify a Stop Loss contact and create a secure HCS account administered by NYS DOH. The Stop Loss Unit must be informed of any changes to the Stop Loss contact.

After establishing the Stop Loss contact and creating the secure HCS account, managed care plans must upload and submit a .txt file through the HCS in adherence to the file specifications found below the HCS account registration links:

HCS Log-in

https://commerce.health.state.ny.us/public/hcs_login.html
https://apps.health.ny.gov/pub/usertop.html
https://apps.health.ny.gov/pub/ctrldocs/paperless_edoc2.pdf
https://commerce.health.state.ny.us/hpn/ctrldocs/sectran/sft2.0_qrg.pdf

Managed Care plans should make sure HCS E-mails are checked weekly because the Stop Loss Unit sends Payment/Failure Summaries through HCS, as well as any other correspondence including PHI, and packages expire after 14 days.

The Stop Loss team mailbox is not a secure portal. If your communication includes patient sensitive information (PSI), then you must use the HCS. Due to restriction of the HCS, Stop Loss cannot establish a team mailbox. For this type of correspondence, Plans should send an e-mail to the Stop Loss mailbox (stop.loss@health.ny.gov) alerting the team that there is supporting documentation sent through the HCS portal.

File Specifications

https://www.health.ny.gov/facilities/hospital/reimbursement/stoploss/file/

Format Specifications:

- File should be submitted as tab-delimited text
- First row must contain field names
- All columns in layout must be included whether or not they are to be used. Do not move the columns around and, if a column is added, make sure it is at the end of the file specifications so as not to negatively impact processing.
- DO NOT submit IP, MH, and RHCF claims in the same file
- DO NOT mix benefit years (Admit Dates) in the same file
- DO NOT submit more than 50 CINs per .txt file

- Use the preferred naming convention i.e., rate code, benefit year and date of submission (Example: 2299_2022_120122). Anything additional can be added as a suffix, e.g., adj, resubmission, v2, etc.
- If submitting HCO supporting documentation, it should be the UB04 in .pdf format. The preferred naming convention is CIN, benefit year and date of submission (Example: ABXXXXXC_2022_120122)

- The Stop Loss claim must be submitted to the Fiscal Agent in your normal claim submissions mode, either on paper (UB04) or an approved HIPAA compliant electronic format (837I)
- It is imperative that an Encounter claim is submitted through the All Payer Database (APD), and a Pended claim submitted through ePaces for each INPATIENT stay submitted to Stop Loss
- RHCF stays require a Pended claim only and no Encounter
- Encounters must include the Admit and a Discharge date of the stay; this includes intermittent billing – the beginning of the next week's billed stay is the "admission" date of that "stay," and the end of the week billed is the "discharge" date of that "stay"
- The codes submitted on the .txt file should match the codes submitted on the Encounter – the APR-DRG derived from the grouping of the encounter coding is used to calculate the payment methodology of the stay submitted on the txt file – not the coding of the txt file.
- It is suggested that the plan submit only one Stop Loss claim per member for all hospital stays, not one per stay (except for MH as of 1/1/2016), for any given benefit year (and calendar year for RHCF)
- Only claims that have been paid to the provider of service may be submitted for Stop Loss reimbursement
- If submitting inpatient stays paid to the facility as high-cost outliers (HCO), include the supporting facility bill (UB04) documentation in PDF format, with the .txt file submission, through the Health Commerce System. It is imperative that the recipient's name, date of service, total charges and name of facility on the .txt file matches the HCO supporting .pdf document.
- Verify date(s) of Medicaid eligibility and Managed Care enrollment
- Verify Permanent Placement and/or NCode status within a member's eligibility, and DO NOT submit these stays as RHCF.
- The date of service on the pending claim may equal the claim submission date, but cannot be later than the last date for which the member 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** – *see below under* **Revised Protocol for Stop Loss Claims Denied for Edit 01292.** **Do not enter a spanned date of service as this frequently results in the claim systematically denying for eligibility.**
- Always verify and use the member's actual date of death as the last date of coverage and date of service instead of the end of the month of the MMC enrollment period
- Do not use the 1st of the month; the claim will duplicate against the monthly capitation claim
- Do not use the same date of service as the mom and/or baby hospital claim
- **Claims will be held to a two-year limit for proper submission**
- If the last day of the member's plan enrollment is over two years from the pending claim submission entry date to ePaces, 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, Medicaid remittance showing the timely filing edit 01292 denial, and all original attachments should be sent to the address noted below under "Revised Protocol for Stop Loss Claims Denied for Edit

01292." The Plan must also submit an explanation of the circumstances causing the delay in billing.

Note: In *special circumstances with prior authorization from the Stop Loss Unit*, plans may submit paper claims. 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.

Paper submissions can be uploaded as individual cases and sent to Stop Loss staff via the HCS.

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 submitted to NYS DOH's Stop Loss Unit, and be payable, within two years from the close of the benefit year in order to be valid and enforceable against the NYS DOH.

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 NYS DOH 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 60 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
Attn: Medical Pended Claims/Two-Year Claim Review
1 Commerce Plaza, Room 1206
Albany, NY 12260
800-342-3005 Option 3

* 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 member's plan enrollment, or
- the last day of the member's Medicaid eligibility, or
- the member'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 member was in fact enrolled in the plan during the specific time period indicated by dates of service.

- The Stop Loss threshold is applicable for that plan and time period, based on executed contracts/amendments between the plan and the member's Local Department of Social Services (LDSS), 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;
- Only services covered by the applicable Stop Loss policy and benefit package 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

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. The $200,000 Inpatient threshold ($100,000 1/1/2010 through 12/31/2021) would include the hospital costs if paid by the plan, 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

Valid claims will be processed for adjudication. Plans will be notified of finalization and any changes in the amounts reimbursed on the Claim Summary Payment and Failure Reports. 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 two (2) business days of prior written notice.

Required Audit Documentation

Documentation should consist of an itemized claim from a provider that indicates the member 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.

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

It is important to note that while the NYS DOH 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 **Form UB04** or in the **Electronic HIPAA 837I Format**, the claims should be submitted to the Fiscal Agent while a .txt file should be sent directly to the Stop Loss Unit via the Health Commerce System's Secure File Transfer (SFT).

The following **Q and A** has been created 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 member has either lost Medicaid eligibility or disenrolled from the plan?	**□ Verify date(s) of Medicaid eligibility and managed care enrollment. Submit claims using a date of service that is both within the Medicaid eligibility and the Plan enrollment period.** **□ If a member is no longer enrolled in the plan, submit claims using the last date of plan enrollment as the date of service, or the date of death if the member has expired.**
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.** **□ Enter an adjustment claim in ePaces (last character will be a "2").** **□ Send supporting documents (.txt file) to NYS DOH including ALL the stays for the CIN/Benefit Year. Claims that have been previously denied cannot be adjusted. They should be resubmitted as a new claim.**

	□ 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 the Stop Loss Unit, 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 member who had duplicate benefits, the Plan should return any payments for the overlap period that the Stop Loss Unit has identified. Contact the Fiscal Agent for more information.**
What common mistakes can I avoid when submitting documentation to Stop Loss?	**When submitting inpatient .txt files, make sure that you denote correctly:** **□ the name of the eligible member** **□ Admit and Discharge dates of service** **□ member'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 that doesn't involve PHI, please submit your inquiries to:** **stop.loss@health.ny.gov** **All other inquiries must be sent through HCS.**
Why are my claims denied or paid less than the amount I expected?	**Commonly, plans submit ineligible bills such as claims incurred while the member was enrolled with a different MCO or All Benefits plan. Also, plans are encouraged to group their claims prior to submission to better identify expected reimbursement.** **Be sure to use the correct version of the 3M APR-DRG Grouper in effect for the dates of service, as outlined by the NYS DOH in the Plan Letter that is mailed informing plans of rate updates.**

Outlier and transfer cases rates of Payment:

Commonly, plans submit a transfer claim that does not qualify under regulations. A transfer qualifies strictly for inpatients who are transferred to another non-exempt hospital (disposition code 02 and is not submitted with APR DRG 580.1-580.4 or 581.1-581.4). For more information, please refer to https://regs.health.ny.gov/content/section-86-121-outlier-and-transfer-cases-rates-payment.

Section IV – Appendix

STOP LOSS FORMS

In order to submit documentation for Stop Loss claims to the NYS DOH, the following are required forms and/or attachments:

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 for each Plan ID in order to submit claims to Stop Loss.**

Claim Cover Sheet (when submission of a paper claim has been approved):

- **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 837I, documenting total hospital charges for a high cost outlier stay must accompany the claim.**
- **A claim cover sheet must accompany all paper claims submitted to Stop Loss.**

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

One Inpatient stay sheet is attached, APR-DRG for stays on or after 1/1/2010

- **The diagnoses and procedure codes provided on this form must group to**
- **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 for Stop Loss does not apply to inpatient stays for detoxification in Article 28 hospitals. In this setting, detox (ICD 10 PCS Code HZ2ZZZZ) is considered a medical issue, not mental health, and must be submitted under the General Inpatient Rate Code 2299.**

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, day care, or permanent placement status (see previous link to Exceptions/Restrictions "N" codes).**

Prior approval paper claim submission cover sheets:

STOP LOSS CLAIM COVER SHEET

Plan Name_____ Plan Medicaid Identification #_____

Date _____ Plan Stop Loss Contact _____

Contact's e-mail_____ Contact's Telephone # _____

Member Name_____

Member 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. 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:

1)	2)	3)	4)	5)
6)	7)	8)	9)	10)

***All inpatient stays designated as HCO must be accompanied by documentation of the total charges for that stay (ex. UB-04, 837I, screen print of electronic transactions).**

INPATIENT STAY – RATE CODE 2299/2296 (SNPs)

Managed Care Plan Name _____ Plan Medicaid ID# _____

Hospital's Full Name _____

Out of State Hospital Address _____

Hospital MMIS ID# _____ Hospital NPI #_____

Patient Name_____ Patient CIN # _____

Admit Date_____ Discharge Date _____ LOS _____

Acute Care Days _____ ALC Days _____

Date of Birth _____ Age _____ Gender _____ Birth Weight _____ (grams)

Disposition (status) __ __ Admitting Diagnosis _____

(Must be a 2-digit code)

ICD-9/ICD-10 Diagnosis(es)

Dx Code	POA	Dx Code	POA	Dx Code	POA	Dx Code	POA	Dx Code	POA	Dx Code	POA
P)		2)		3)		4)		5)		6)	
7)		8)		9)		10)		11)		12)	
13)		14)		15)		16)		17)		18)	
19)		20)		21)		22)		23)		24)	

ICD-9/ICD-10 Procedure(s)

P)	2)	3)	4)	5)	6)
7)	8)	9)	10)	11)	12)
13)	14)	15)	16)	17)	18)
19)	20)	21)	22)	23)	24)

APR – DRG _____ SEVERITY LEVEL _____ SIW_____

AVERAGE LENGTH OF STAY (ALOS) _____

Hospital Charge _____ Amount Paid by Plan_____

Claim calculated as:

☐ Inlier ☐ Transfer ☐ Exempt Unit

☐ High Cost Outlier** Exempt Unit Type (*) _____

(*) Specialty Hospital, Drug Exempt, Other Exempt, Psychiatric Exempt, Medical Rehab

** include copy of hospital charges

BEHAVIORAL HEALTH INPATIENT STAY RATE CODE 2295

Managed Care Plan Name _____ Plan Medicaid ID# _____

Hospital's Full Name _____

Out of State Hospital Address _____

Hospital MMIS ID# _____ Hospital NPI# _____

Patient Name_____ Patient CIN # _____

Admit Date _____ Discharge Date _____ LOS _____ ALC Days _____

Date of Birth _____ Age _____ Gender _____

Disposition (status) __ __ Admitting Diagnosis _____

(Must be a 2-digit code)

Mental Retardation Diagnosis Code _____ Adjustment Factor _____

Comorbidity Diagnosis Code _____ Adjustment Factor _____

(Use highest factor)

ICD-9/ICD-10 Diagnosis(es)

Dx Code	POA	Dx Code	POA	Dx Code	POA	Dx Code	POA	Dx Code	POA	Dx Code	POA
P)		2)		3)		4)		5)		6)	
7)		8)		9)		10)		11)		12)	
13)		14)		15)		16)		17)		18)	
19)		20)		21)		22)		23)		24)	

ICD-9/ICD-10 Procedure(s)

P)	2)	3)	4)	5)	6)
7)	8)	9)	10)	11)	12)
13)	14)	15)	16)	17)	18)
19)	20)	21)	22)	23)	24)

Electroconvulsive Therapy (ECT)

Total # of treatments (*) _____ (*) List dates for treatments below

APR-DRG _____ Amount Paid by Plan _____

Claim calculated as:

☐ DRG ☐ Per Diem ☐ Exempt Unit Exempt Unit Type (**) _____

(**) Drug Exempt, Psychiatric Exempt

(*) ECT Continued:

Dates: _____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Residential Health Care Facility (RHCF) Stay
RATE CODE 2297

Managed Care Plan Name_____ Plan Medicaid ID#_____

RHCF Full Name _____

RHCF MMIS ID# _____ RHCF NPI # _____

Patient Name _____ Patient CIN # _____

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 _____
(Requires additional attestation)

Number of Prior Authorized Bed Reservation Days included in LOS Above_____
(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 _____

Available Resources for Assistance

eMedNY Support

□ 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 including:

https://www.eMedNY.org/toolscenter.aspx

https://www.eMedNY.org/selfhelp/

□ 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. Manuals are available for claim submission through ePaces.

□ 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 WEBSITES

□ Contains valuable information concerning rates, SIWs, Letters to Health Plans, links to nursing home rates, calculation sheets, a complete list of all health care facilities in New York, including OPCERT numbers.

https://www.health.ny.gov/facilities/hospital/reimbursement/stoploss/

https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/

https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/index.htm

□ Information on Encounter submission via the All Payer Database and direct contact

https://nyshc.health.ny.gov/web/nyapd/home

https://nyshc.health.ny.gov/web/nyapd/apd-regulations-guidance-manuals

https://www.apcdcouncil.org/state/new-york

Failure Report Messages

INPATIENT

Claim Not Found Pending in eMedNY (By CIN) **–** There is no pending claim entered into ePaces for Stop Loss to match and is necessary to finalize the submitted stay(s). Claims entered into ePaces could take up to two weeks to appear on our inventory report known as Mobius, and seen in eMedNY. Claims can be entered with the last day of the benefit year, but cannot be entered with a date later than the member's termination from the plan, the member's expiration (death), or prior to their enrollment date.

Failure to Meet Eligibility Requirements (By CIN & Admit Date) **–** The member's eligibility was not checked in the Medicaid Eligibility Verification System (MEVS) prior to submission and was either not participating in a Prepaid Capitation Plan (PCP) at the time of services, or was terminated, or expired.

Resubmit As 2295 (By CIN & Admit Date) **–** The services billed are covered under the Inpatient Psychiatric Mental Health benefit coverage of Stop Loss, and are for substance abuse rehabilitation services or psychiatric disorders. Detoxification is covered under the Inpatient benefit coverage of Stop Loss rendered in an Article 28 Hospital. The new, or adjusted, Encounter should reflect the correct rate code 2295 as well as the pended claim.

Duplicate Claim Submission Possible (By CIN) **–** The system has detected payment previously made for the same Benefit Year. Additional stays must be submitted as an adjustment against the original paid claim. An adjustment claim must be entered into ePaces, and the TCN (that will have a suffix "2") entered in the corresponding column of the .txt file as instructed in the Specifications. All stays are then submitted on the same .txt file as if they are the original submission.

DOH Encounter Not Grouped: Please resubmit (By CIN & Admit Date) **–** The Encounter that was entered was grouped to a different 3M APR-DRG Grouper than the version currently used by the NYS DOH, and it cannot group to the same DRG due to inconsistent ICD-10 codes. The version being utilized for the stay submitted can be found at the following location and is provided in the Health Plan Letters that are sent out yearly, or whenever a rate change or update warrants it.

https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/ffs/index.htm

Encounter Not Found (By CIN & Admit Date) **–** An Encounter was not found by the system with which to match and derive a DRG and SOI code to apply the appropriate SIW to adjudicate the claim with a payment. Encounters must be entered with the actual Admit and Discharge dates of the stay in order to price the stay appropriately, so it is imperative that they are entered within the two-year timely filing period.

Stay or Claim Denials (By CIN &/or Admit Date) **–** Here you will find many different denial messages, and informational messages i.e., "Calculated DRG does not Match reported DRG." This is usually a result of the encounter coding and grouping not matching the billed .txt file. This is **NOT** a denial and the claim has paid but at a different rate than was reported by the

Plan. This message will also be generated when Exempt Unit per Diem pricing is made for Specialty Hospitals and Medical Rehab.

RESIDENTIAL HEALTH CARE FACILITY (RHCF)

Claim Not Found Pending in eMedNY (By CIN) **–** There is no pending claim entered into ePaces for Stop Loss to match and is necessary to finalize the submitted stay(s). Claims entered into ePaces could take up to two weeks to appear on our inventory report known as Mobius, and seen in eMedNY. Claims can be entered with the last day of the benefit year, but cannot be entered with a date later than the member's termination from the plan, the member's expiration (death), or prior to their enrollment date.

Failure to Meet Eligibility Requirements (By CIN & Admit Date) **–** The member's eligibility was not checked in the Medicaid Eligibility Verification System (MEVS) prior to submission and was either not participating in a Prepaid Capitation Plan (PCP) at the time of services, or was terminated, or expired. These members can also be placed in Long Term or Permanent Placement.

Adult Day Care (By CIN & Admit Date) **–** The member is enrolled in a program that offers Adult Day Care which is not a reimbursable covered benefit under the Stop Loss program.

Principal Provider (By CIN & Admit Date) **–** The member is enrolled in a permanent placement status and resides full time in a residential facility rather than for rehabilitation services. Stays are not a reimbursable covered benefit under the Stop Loss program. Member eligibility **must** be verified prior to submission of claims to Stop Loss.

Rate Code (N1 ~ N6) (By CIN & Admit Date) **–** The member has Exception/Restriction Codes on their eligibility status indicating Long Term or Permanent Placement rather than for rehabilitation services. Stays are not a reimbursable covered benefit under the Stop Loss program. Member eligibility **must** be verified prior to submission of claims to Stop Loss.

Duplicate Claim Submission Possible (By CIN) **-** The system has detected payment previously made for the same Benefit Year. Additional stays must be submitted as an adjustment against the original paid claim. An adjustment claim must be entered into ePaces, and the TCN (that will have a suffix "2") entered in the corresponding column of the .txt file as instructed in the Specifications. All stays are then submitted on the same .txt file as if they are the original submission.

Stay or Claim Denials (By CIN &/or Admit Date) **–** Here you will find different denial messages pertinent to RHCF stays.

PSYCHIATRIC INPATIENT MENTAL AND BEHAVIORAL HEALTH (MH & BH) – includes Substance Use Disorders (SUD)

Claim Not Found Pending in eMedNY (By CIN) **–** There is no pending claim entered into ePaces for Stop Loss to match and is necessary to finalize the submitted stay(s). Claims entered into ePaces could take up to two weeks to appear on the inventory report known as Mobius, and seen in eMedNY. Claims can be entered with the last day of the benefit year*, but cannot be entered with a date later than the member's termination from the plan, the member's expiration (death), or prior to their enrollment date.

***As of 01/01/2016, Inpatient Psychiatric Admissions *are no longer cumulative* for a benefit year (unless stays are consecutive and the result of a transfer from/to a psychiatric facility or unit within the hospital) and each one is episode specific as explained on Page 5. Those claims should be submitted if the threshold has been met for Stop Loss reimbursement, and not held until the end of the benefit year.**

Failure to Meet Eligibility Requirements (By CIN & Admit Date) **–** The member's eligibility was not checked in the Medicaid Eligibility Verification System (MEVS) prior to submission and was either not participating in a Prepaid Capitation Plan (PCP) at the time of services, or was terminated, or expired.

SSI Categorized at Time of Service **–** Prior to 01/01/2016, members enrolled in SSI are not eligible for Stop Loss reimbursement for Inpatient Psychiatric Services.

Encounter Not Found (By CIN & Admit Date) **–** An Encounter was not found by the system with which to match and derive a DRG and SOI code to apply the appropriate SIW to adjudicate the claim with a payment. Encounters must be entered with the actual Admit and Discharge dates of the stay in order to price the stay appropriately, so it is imperative that they are entered within the two-year timely filing period.

Stay Verified As Detox – Resubmit as 2299 **–** Inpatient mental health coverage for Stop Loss does not apply to inpatient stays for detoxification in Article 28 hospitals. In this setting, detox (ICD 10 PCS Code HZ2ZZZZ) is considered a medical issue, not mental health, and must be submitted under the General Inpatient Rate Code 2299. This stay should be resubmitted as an Inpatient Stay. The new, or adjusted, Encounter should reflect the correct rate code 2299 as well as the pended claim.

Duplicate Claim **-** The system has detected the same stay previously submitted that was paid or denied.

Services prior to 01/01/2016: The system has detected payment previously made for the same Benefit Year. Additional stays must be submitted as an adjustment against the original paid claim. An adjustment claim must be entered into ePaces, and the TCN (that will have a suffix "2") entered in the corresponding column of the .txt file as instructed in the Specifications. All stays are then submitted on the same .txt file as if they are the original submission.

Stay or Claim Denials/Discrepancies **–** Here you will find different denial messages pertinent to IP Psychiatric stays.