Empire BlueCross BlueShield
An Anthem Company

Empire provider meet and greet

Empire MediBlue HealthPlus Dual Plus (HMO D-SNP)

Medicaid Advantage Plus (MAP)

This communication applies to the Medicaid and Medicare Advantage programs from Empire.

Agenda

- Who we are: overview of Empire
- Medicaid Advantage Plus (MAP) transition and overview
- Empire case management and care coordination support
- Benefits, authorization, and utilization management overview
- Claims and appeals
- Key contacts
- Appendix

Program and benefits overview

About us

- Empire has been serving New York for over 85 years
- We offer free or low-cost health plans
- Over 500,000 Empire members (excluding QHP, Commercial, and Medicare)
- We serve: New York City, Long Island, Eastern New York, and upstate New York.
- Over 170 languages spoken
- Provider network of over 40,000 doctors

Mission and vision

- Mission:
  - Improving lives and communities.
  - Simplifying healthcare.
  - Expecting more.
- Vision:
  - Be the most innovative, valuable, and inclusive partner.

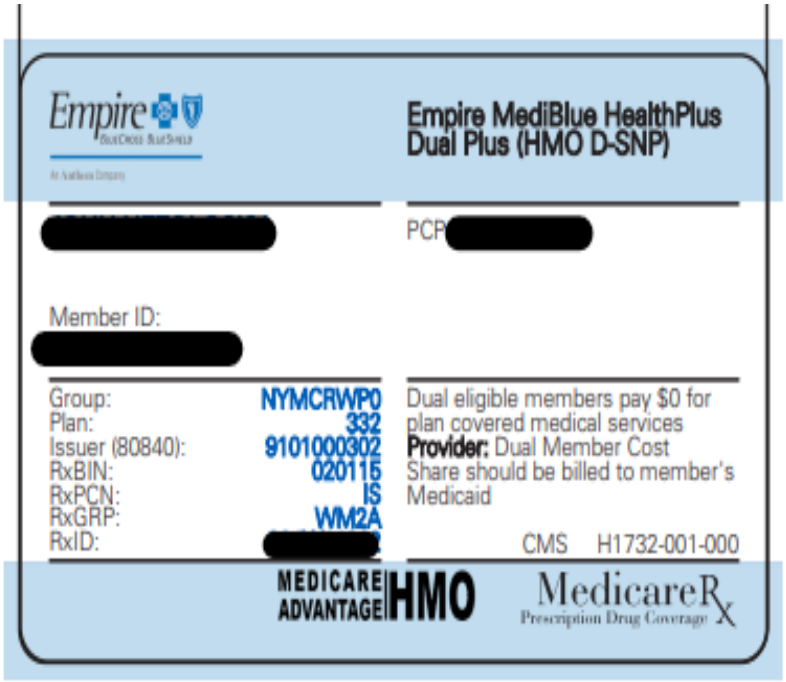
Empire MediBlue HealthPlus Dual Plus (HMO D-SNP)

- Empire MediBlue is an integrated plan for members who receive long-term services and supports and have dual coverage under Medicare and Medicaid.
- Empire MediBlue is an integrated product that covers all Medicare and Medicaid covered benefits.
- This plan supports members in long-term care services like home care and personal care in order to stay in their homes and communities as long as possible.
- The plan began offering this product in 2022.
- The Medicare covered behavioral health (BH) benefits are currently covered.
- Effective January 2023, the Medicaid covered BH benefits will be carved in.
- **Note:** This dual integrated plan is also known as FIDE/MAP

Managed Long-Term Care (MLTC)

- MLTC plan is an entity that receives Medicaid funding to arrange, coordinate, and pay for health and long-term care services for people who are chronically ill and/or have disabilities. Under MLTC, Empire members receive coordination of medical, specialty, and home- and community-based services, to help maintain or improve their quality of life and overall health, despite chronic illness.
- As members of Empire, they also receive:
  - A care manager, a registered nurse who will help ensure that they receive appropriate, timely care that meets their specific needs.
  - A reassessment nurse (registered nurse) who will visit them in their home or the nursing facility where they reside to assess their needs.
  - A personalized person-centered service plan (PCSP) that members and those they designate, the care manager, and their primary care provider design just for them.
  - Extensive choices in providers that offer (MLTC) benefits.
  - Access to the Empire 24/7 NurseLine to answer questions.

Member ID card



January 1, 2023, transition

Effective January 1, 2023, services include:

CORE services for Medicare Advantage Plus or Health and Recovery Plan:

- Community psychiatric supports and treatment
- Empowerment services
- Peer supports
- Family support training
- Psychosocial rehabilitation

Office of Addiction Services and Supports (OASAS):

- Outpatient opioid treatment, and the following freestanding inpatient programs:
  - ATCs, inpatient rehab, inpatient Detox, residential services (Part 820).

Office of mental health (OMH):

- Assertive community treatment (ACT) Continuing day treatment (CDT)
- Comprehensive Psychiatric Emergency Program (CPEP)
- Partial hospitalization
- Personalized recovery-oriented services (PROS)
- Adult crisis intervention (CI)

Person-centered, recovery-oriented

Our approach to managing these services are person-centered and recovery focused.

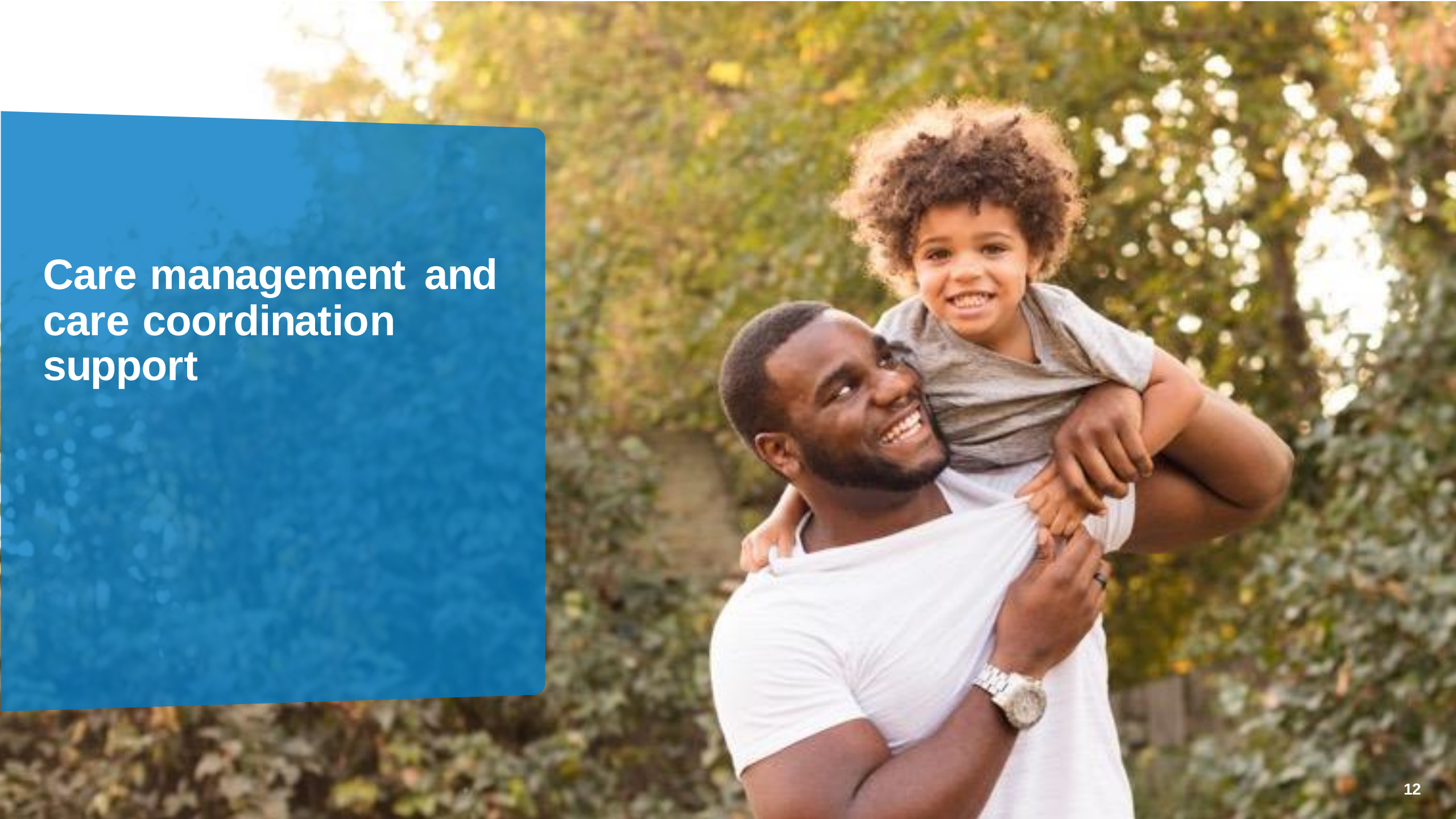
This approach provides:

- Treatment options and choices.
- An emphasis on supporting the member's identified treatment goals and encourages autonomy.
- The use of open-ended questions to highlight:
  - Strengths
  - Passions
  - Interests
  - Accomplishments

Person-centered, recovery-oriented (cont.)

- How can we use this approach?
  - Clinical staff create treatment plans using person-centered language.
  - We conduct clinical rounds with person-centered summations and discussion.
  - Resources and tools for members have appropriate recovery-oriented language.
  - We share the goal of having members stay in the least restrictive environment during their recovery process.

Care management and care coordination support



Case management and care coordination overview

Mission:

- To empower members to effectively manage their healthcare needs across the continuum by coordinating quality healthcare services and the optimization of benefits through a realistic, cost-effective, and timely case management plan. The case management model is a component of our Population Health Management strategy. The value of case management will be evidenced by best practices and quality outcomes that contribute to the optimal health, function, safety, and satisfaction of our members.

Case management and care coordination overview (cont.)

- Case management focuses on the timely, proactive, collaborative, and member centric coordination of services for individuals identified with complex conditions. Case managers identify members by medical or behavioral diagnosis or condition, high utilization of services, financial or utilization-based triggers, health risk assessments, electronic health records, self-referrals, or other appropriate sources and adjust its procedures to facilitate linking members with services that meet their needs and achieve their goals.

Utilization, claims payment, and provider resources

Utilization management/authorization

- Utilization management and eligibility requirements for mental health and addiction services included in the MAP benefit package will be the same as the requirements in Medicaid for Health and Recovery Plans (HARPs) and the mainstream managed care benefits.

MAP claims

The *NYS Medicaid Advantage Plus Plans Behavioral Health Billing and Coding Manual* supporting documents:

- Medicaid reimbursement schedule:
  - https://omh.ny.gov/omhweb/medicaid_reimbursement/
- Ambulatory patient groups (APGs) are not included in the rate table:
  - https://www.health.ny.gov/health_care/medicaid/rates/apg/
- The government rate table and coding taxonomy can be found on the OMH website at:
  - https://omh.ny.gov/omhweb/bho/map-coding-taxonomy-for-bh-services.xlsx

Claims, denials, and contracting

May be conducted:

- Online
- Availity Essentials Single Claim Submission
- EDI 837 via Clearinghouse/ Billing Vendor or Direct Connection With Availity Essentials
- By mail

Paper claims submission

- You have the options of submitting paper claims. We use the optical character (OCR) technology as part of our front-end claims processing procedures.
- To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. You must submit a properly completed UB-04 or CMS-1500 (current form) within 90 days from the date of service.
- We cannot accept claims with alterations to billing information:
  - Claims that have been altered will be returned to you with an explanation of the reason for the return.
- We will not accept entirely handwritten claims.

Paper claims submission (cont.)

- Paper claims must be submitted within 90 days of the date of service and submitted to the following address:

Empire

P.O. Box 1407 Church Street Station

New York, NY 10008-1407

Claims

Facility claims must be submitted with the following:

- Form type for Medicare and Medicaid — *CMS-1450 (UB-04)* submission.
- Valid value code, if applicable.
- Valid rate code, if applicable.
- Valid revenue code.
- Valid CPT® code.
- Bill type must be 731 for initial claims or 737 for corrected claims.
- Valid diagnosis code that falls within the mental health category.

Individual and group practice claims must be submitted with the following:

- Form type for Medicare and Medicaid — *CMS-1500* submission.
- Valid CPT code.

Rejected versus denied claims

The difference between rejected and denied claims:

Rejected claims can be viewed on the lectronic response reports received from Availity Essentials or clearinghouse/billing vendor.

Claims adjudication and payment disputes

To avoid claims rejections and denials, ensure a clean claim is submitted by checking the following:

- Claim is submitted timely within 90 days from the date services are rendered.
- Claim is billed accurately with the corresponding CPT, revenue code, rate code, modifiers, etc.
- Claim is submitted within 90 days of receiving a response from the third-party payer in the case of other insurance.

Claim payment disputes must be filed within 45 calendar days from the adjudication date provided on the *EOP*:

- Payment dispute forms can be located on the provider website or by using Availity Essentials.

BH facility contacts

- If your facility Name starts with A-L, your delegated Network Manager is Marisol Matos.
- If your Facility Name Starts with L-Z, your delegated Network Manager is Traci Bennet.

Lan resources and contact information

Resources

- Member Services at: **833-713-1080**
- Provider Services claim status: **800-676-BLUE** (2583)
- Provider Experience: *Email Form*
- Availity* Client Services: **800-282-4548**
- Provider manual, quick reference guide, and general information can be located on our website: https://providerpublic.empireblue.com
- **24/7 NurseLine:** You can call our 24/7 NurseLine and speak directly to a nurse at **800-950-7679** (TTY 711).
- Behavioral health call center and after-hours acute services can be reached at **800-300-8181**.

Appendix

Authorization/notification

- Request precertification and give us notification:
  - Using our preferred method online at https://providerpublic.empireblue.com.
  - Phone: **800-450-8753**
  - Fax (for medical requests only): **800-964-3627**

- **Precertification:** Precertification means the authorization of specific services or activities before they are rendered or occur:
  - This is also known as prior authorization (PA).

- **Notification:** Notification is telephonic, fax, or electronic communication received from a provider to inform us of their intent to render covered medical services to a member. Give us notification prior to rendering services outlined in this document:
  - For emergency or urgent services, give us notification within 24 hours or the next business day

Electronic data interchange (EDI)

- To become a direct EDI trading partner, visit https://www.availity.com:
  - If you are already an Availity user, login and choose **My Providers > Transaction Enrollment**.
  - If you are a new user to Availity, select **Register**.
  - Availity's payer IDs: https://apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/.
  - Requires Practice Management, Electronic Health Record or Billing Software

Note: If you use a clearinghouse, billing service, or vendor, please work with them directly to determine payer ID for submission to Availity Essentials EDI Gateway.

- Electronic remittance advice (835)
- Use Availity to register and manage electronic remittance advise (ERA) account changes with these three easy steps:
  1. Log in to Availity at https://www.availity.com.
  2. Select **My Providers**.
  3. Select **Enrollment Center > Transaction Enrollment**.

Note: If you use a clearinghouse, billing service or vendor, please work with them on ERA registration.

EDI (cont.)

Electronic Funds Transfer (EFT):

- Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes.
- EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.
- Use EnrollSafe (https://enrollsafe.payeehub.org) to register and manage EFT account changes.

If you have any questions, contact EnrollSafe at 877-882-0384 or support@payeehub.org.

EDI (cont.)

Useful EDI documentation:

- *Availity EDI Connection Guide* —This guide includes information to get you started with submitting EDI transactions to Availity, from registration to ongoing support.
- *Availity EDI Companion Guide*— This guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity:
  - Used for direct submissions to Availity Essentials using practice management, electronic health record or billing software
- X12 code descriptions used on EDI transactions can be located at - https://x12.org/reference

* Availity, LLC is an independent company providing administrative support services on behalf of Empire.

Medicaid: https://providerpublic.empireblue.com | Medicare Advantage: https://www.empireblue.com/medicareprovider

NYBCBS-CDCR-008812-22 October 2022