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 $50,000 per enrollee per calendar year are the liability of the plans. For amounts paid in excess of $50,000 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, 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 DOH 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

All Mainstream Medicaid and HIV SNP plans are eligible for the following 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 mental health treatment outpatient visits in excess of twenty (20) visits during any calendar year at rates set forth in contracted fee schedules. Court Ordered Services for mental health treatment outpatient visits specifying the use of Non-Participating Providers will be reimbursed at the Medicaid rate of payment.

- **Through March 31, 2002**: Medically necessary and clinically appropriate Medicaid reimbursable alcohol and substance abuse treatment outpatient visits in excess of sixty (60) visits during any calendar year at rates set forth in contracted fee schedules. Court Ordered Services for alcohol and substance abuse treatment outpatient visits specifying the use of Non-Participating Providers will be reimbursed at the Medicaid rate of payment. **Effective April 1**, 2002, alcohol and substance abuse treatment outpatient visits will no longer be a covered benefit under the Medicaid managed care program and stop loss coverage will terminate.

- Medically necessary and clinically appropriate Medicaid reimbursable inpatient mental health services and/or inpatient alcohol and substance abuse treatment services 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 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) 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

Prior to 2003, plans purchasing general hospital inpatient reinsurance from NYS have used designated rate code 2299 to submit all stop loss claims to the state, including those relating to mental health, alcohol and substance abuse. Effective January 2003, Mainstream Medicaid plans should only use rate code 2299 to submit hospital inpatient claims in excess of $50,000 per calendar year. For other 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
2294	➢ > 20 Outpatient Mental Health Visits	Mainstream Medicaid, HIV SNP
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 (Nursing Home) Days	Mainstream Medicaid, HIV SNP
2299	➢ Inpatient Expenditures > $50,000 Per Enrollee Per Year, 20% Coinsurance For Payments Up To $250,000	Mainstream Medicaid

Important – Effective March 20, 2005, it is no longer acceptable to enter a trailing fifth digit zero after the rate code when submitting a claim.

Also note there is no reinsurance coverage of any type provided by NYS for the Family Health Plus, Child Health Plus and Medicare/Medicaid Advantage Dual Eligible programs, which should be covered by private reinsurance.

Process for Submission of Stop Loss Claims

An Expedited Process for submission of stop loss claims has been developed for claims submitted on or after August 1, 1997. Under this process, 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. Revised 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.

Submission of Stop loss Claims

- Stop loss claims must be submitted to the Fiscal Agent in your normal claim submission mode, either on paper or an approved HIPAA compliant electronic format. **Note the following changes effective March 20, 2005:**

  - It is no longer necessary to enter a trailing fifth digit zero after the rate code when submitting a claim;

  - It is no longer necessary to submit multiple claims for amounts greater than 100,000. Stop loss claims of $100,000 or greater can be submitted on one claim form.

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 recipient was covered by the Plan and must not be the first of the month or the claim will be denied. If the last day of the recipient's plan enrollment is over two years from the stop loss submission date, then the original claim and the attachments must be sent to the address noted below. The plan also must submit an explanation of the circumstances causing the delay in billing. Claims of this type should first be sent to the Fiscal Agent. Refer to the Billing Guidelines section of the CSC Medicaid Managed Care Manual for additional information on stop loss billing.

Claims will be held to a two-year limit for proper submission. All claims for payment must be finally submitted to the Fiscal Agent, and be payable, within two years from the close of the benefit year in order to be valid and enforceable against the Department. That is, 2002 payable claims must be finally submitted no later than December 31, 2004 with corresponding cutoff for future years.

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

NYS Department of Health
Office of Medicaid Management
Bureau of Medical Review & Payment
Suite 6E - Pended Claims - Stop Loss
150 Broadway
Albany, New York 12204-2736
1-800-562-0856

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 (see description of stop loss policy parameters in the Background Section) 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 $50,000 inpatient threshold ($100,000 for HIV SNPs) 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. Submitted claim amounts may be adjusted 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 billed on the remittance statement. Detail regarding specific changes will be provided to plans by request at 1-800-562-0856. A plan may submit revised information for an inpatient claim, if it would support a re-determination of the Medicaid calculated hospital payment.

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, 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 UB92 or 837 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 or SSI related at the time of service and with more than 20 mental health treatment outpatient visits during the calendar year, the plan will be compensated for additional visits at amounts set forth in contracted fee schedules.

- For enrollees not categorized as SSI or SSI related at the time of service and with more than 60 alcohol and substance abuse treatment outpatient visits (through March 31, 2002) during the calendar year, the plans will be compensated at the contracted fee schedules for medically necessary and clinically appropriate Medicaid services provided in excess of this amount. Effective April 1, 2002, outpatient alcohol and substance abuse treatment services are no longer covered under Medicaid managed care but are available under the Medicaid fee-for-service program.

- 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 State operated facility 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 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 recipient 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 recipient is hospitalized or on leave of absence. If the recipient 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 UB92** or in the **Electronic HIPAA 837I Format**, the claims should be submitted to CSC 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:

<u>**Questions**</u>	<u>**Answers**</u>
➢ **What date of service should be used on the claim for instances where the recipient 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 a recipient 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 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 CSC, and send supporting documents to SDOH. (Do not attempt to adjust a claim that has not been paid previously.)
➢ **Can the requested amount on a paper claim form be more than $100,000?**	Yes. Stop loss claims greater than $100,000 can be submitted on one claim form.

➢ **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 attestation, 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.

➢ **How do I avoid 90-day submission denials by Medicaid?**

Use a current date of service except as noted above in Question 1 for eligibility and disenrollment situations.

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

When submitting attestation, inpatient and itemized service forms, make sure that you denote correctly:

- the name of the eligible recipient
- date of service
- recipient identification number
- date of birth
- male or female
- and other pertinent information.

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

If you need further assistance, please contact:

NYS Department of Health
Bureau of Medical Review and Payment
Pended Claims Stop-Loss
150 Broadway Suite 6E
Albany, NY 12204-2736
1-800-562-0856

Section IV –Appendix

STOP LOSS ATTESTATION STATEMENT

STATE OF NEW YORK

________________________________COUNTY:

I,_______________________________________ on behalf of _______________________________ attest
(Name and Position) (Plan name and Medicaid ID #)
that documentation and proof of payment to providers for all claims for the enrollee listed below are available and will be provided upon request for purposes of verifying that appropriate stop loss payments have been made to the plan by New York State on behalf of the enrollee identified below.

I agree that New York State has the right to recoup from ________________________ any moneys
(Plan Name)
paid for Stop loss claims for which appropriate supporting documentation showing payments made to providers for care rendered to the identified enrollee is not available.

Documentation must include date(s) of service, verification that recipient was enrolled in the plan during all dates of service, patient diagnoses, service provider name(s) and identification number(s), proof of amount(s) actually paid to the service provider(s). Such amount(s) should 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, justifiable based on specific plan/provider contract terms, or can be shown to be the amount customarily paid by the plan for the service(s).

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., copayments and other insurance coverage): ____

Net Amount of Stop loss Payment Due Plan _______________________________

I attest that all information provided on this statement and the accompanying form(s) is true and accurate to the best of my knowledge and that the Plan identified above is due this Stop loss payment for the above enrollee.

Signature ____

Print/Type Name ____

Name of Plan ____

_______________________ ____
Date Sworn - Notary Public

INPATIENT STAY

Managed Care Plan Name ____________________ Plan Medicaid ID#___________

Hospital Name_______________________________ Hospital ID#_______________

Patient Name________________________________ Patient ID#________________

Admit Date__________________ Date of Birth_______________

Discharge Date_______________ Age_______ Sex___________

Disposition (status) ___________ Birthweight _______________

DIAGNOSIS

Admit _ _ _ . _ _ Principal _ _ _ . _ _ Other _ _ _ . _ _

Other _ _ _ . _ _ Other _ _ _ . _ _

Procedures (if applicable)

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

Other _ _ _ . _ _ Other _ _ _ . _ _

DRG ________________ Amount Paid ______________

OR

Exempt Unit (specify type, i.e., Psych, Medical Rehab, Substance Abuse) ___________

Amount Paid __________

Residential Health Care Facility (RHCF) Stay

Managed Care Plan Name __________________ Plan Medicaid ID#____________

RHCF Name______________________________ RHCF Medicaid ID#___________

Patient Name______________________________ Recipient ID#________________

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

Admit Date_______________________ Discharge Date______________

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_____________

STOPLOSS ITEMIZED BILL

HMO Name and Medicaid ID
Recipient Name and ID

Service Date	Provider Name	MMIS/Lisence #	Diagnosis	Units/Days	Basis for Claim Payment, i.e., Procedure Code or per Contract	Amount Paid