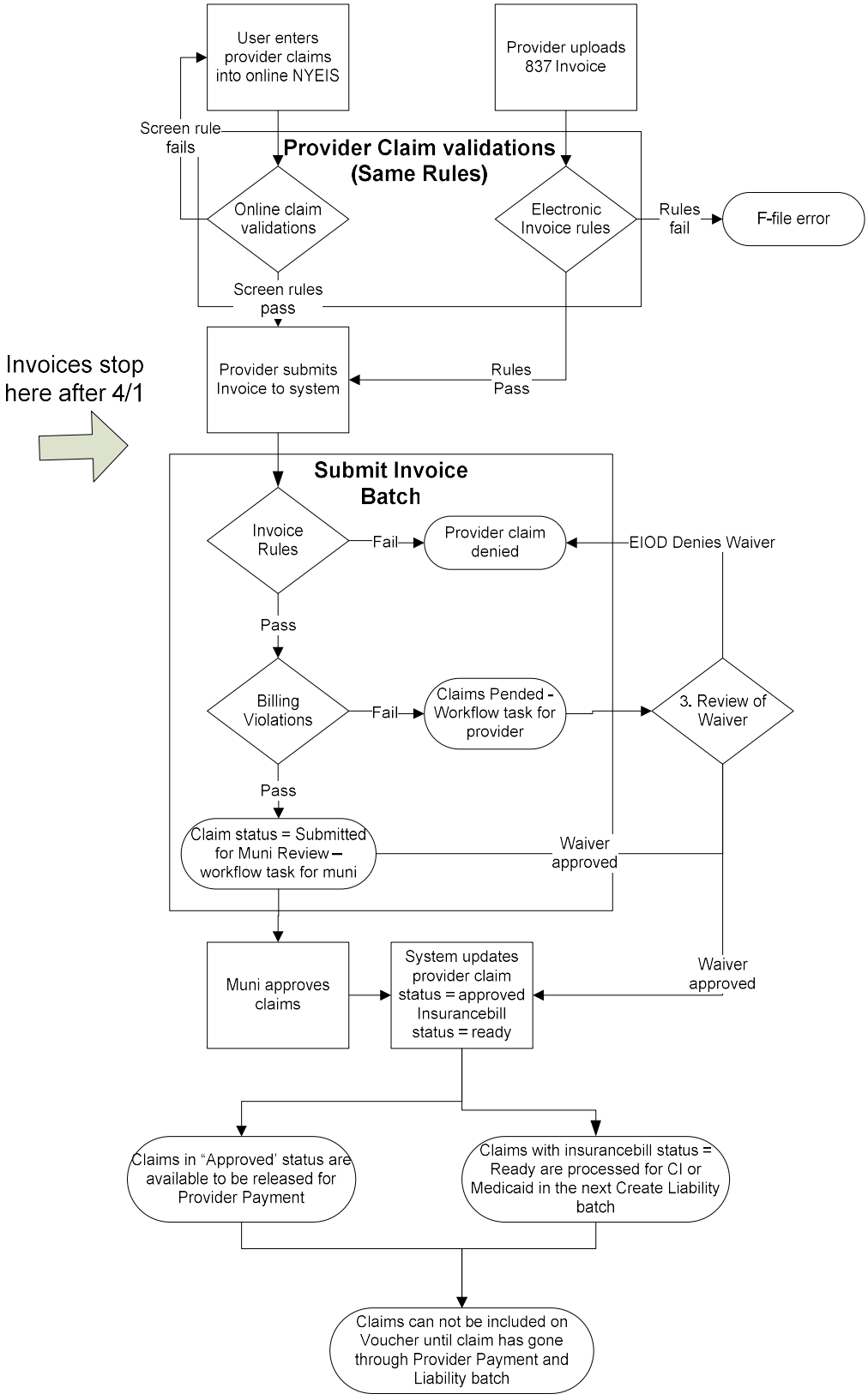
Provider Invoice Business Rules

Provider invoices go through multiple sets of rules to validate the provider claim is correct and appropriate to be paid. These rules are organized into the following rule groups and process sequentially through the system.

1. Electronic Invoice Process: This is a batch that checks each electronically submitted provider invoice for various claiming errors before creating the official invoice record in NYEIS. This batch mirrors the provider claim validations that occur when a user is entering an invoice through online. NYEIS.
2. Invoice Rules: These are provider invoice rules that are run in the Submit Invoice batch. These rules are more complex and process intensive than the validations in the Electronic Invoice process.
3. Billing Violations: These are rules that are run for general service claims after the Invoice rules are run to check against EI specific rules. This rule set is part of the Submit Invoice batch. Claims that fail this rule criteria are pended.
4. Claim amount calculation: For all claims that pass the invoice and billing violations, the approved amount is calculated and assigned to the claim. This is part of the Submit Invoice batch.

The flowchart below outlines the process. The next section describes the various rules that make up each rule group.

Provider Invoice and Downstream Processing



Electronic Invoice Process

Description: The Electronic Invoice process is a batch process which runs at night on a scheduled basis. Providers can submit invoices electronically via use of an 837P file. The Electronic Invoice process checks each electronically submitted provider invoice for various claiming errors before creating the official invoice record in NYEIS.

Trigger: Provider 837P files are accepted by the NYEIS Interface application pre-invoice edits and loaded into staging tables for further processing.

Output: A provider invoice is created in NYEIS. This invoice contains any submitted claims that pass all of the business rules noted in the table below. If a claim does not pass all of the business rules, an F-File error is generated for that claim. Some business rules are associated with the entire invoice and, therefore, affect all of the claims in the electronically submitted invoice. That is, if a business rule at the invoice level triggers an F-File error, then none of the claims submitted with that invoice will be processed further in NYEIS. The F-File responses can be viewed on the provider's Response Files screen.

Business Rule Table

No.	Rule Name	Rule Description
1	Provider Invoice number is a duplicate.	The invoice number is already in NYEIS as a non-voided invoice for the billing provider.
2	Provider does not have a contract for the municipality.	The billing provider on the invoice does not have an active contract with the county designated on the invoice.
3	The rendering provider was not an active employee/contractor of the billing provider.	On the service date recorded in the claim, the rendering provider was not an active employee/contractor of the billing provider. Includes employees of a subcontractor of the billing provider.
4	The rendering provider is not a service coordinator for SC claims.	The rendering provider recorded on the SC claim is not a service coordinator in NYEIS.
5	The rendering provider is not approved for the qualified profession authorized to provide the service.	The rendering provider recorded in the claim is not approved for a qualified profession that is eligible to perform the service designated in the claim.
6	Rendering Provider has a restriction in place on the date of service.	The rendering provider has an active restriction in place on the date of service specified in the claim.
7	Service times are not formatted correctly.	Service times are not formatted correctly in the HIPAA 2300 segment.
8	Invalid Procedure Code	The procedural code entered on the claim line is not recognized as a valid code by NYEIS.
9	Provider not approved	The billing provider is not approved to provide the service on the service date recorded on the claim.
10	Not enough units on SA	The number of units remaining on the service authorization is less than the units required for the claim.
11	Service times are outside of SA date range.	The claim service date does not fall within the service authorization Start Date and End Date.

No.	Rule Name	Rule Description
12	Service date on claim is a future date.	The service date recorded in the claim is in the future.
13	Start and End time is missing for claim	General services need a start and end time and they must be formatted properly.
14	Service Start Time > Service End time.	The service start time recorded in the claim occurs after the service end time.
15	Visit Type is missing.	The service type (visit type) in the 2300 segment is not recorded or not recognized by NYEIS. It must be formatted properly, as well.
16	Provider does not have a contract for the municipality for the service type/method.	The billing provider on the invoice does not have an active contract with the county for the service type on the service authorization as of the service date on the claim. Rule only used if Service date is prior to 4/1/2013.
16A	Provider of Record does not have an Active Appendix Agreement	System checks if provider of record has an active Appendix Agreement. Rule only applies for claims with service date after 3/31.
17	Service coordination claim submitted for same day as another claim.	An approved claim already exists in NYEIS for the service coordination for the child on this date.
18	Rendering Provider is restricted for service type.	The rendering provider is restricted for the product on the date of service specified.
19	Provider Agency is restricted for service type	The agency is restricted for the product on the date of service.
20	Rendering Provider is Student/Intern and has no supervisor for the date of service.	Rendering Provider is Student/Intern and has no supervisor for the date of service.
21	Rendering Provider is Student/Intern and Supervisor's license for the QP has expired.	Rendering Provider is Student/Intern and Supervisor's license for the QP has expired.
22	Rendering Provider is Student/Intern and Supervisor is not approved for the QP on the service date.	Rendering Provider is Student/Intern and Supervisor is not approved for the QP on the service date.
23	Rendering Provider is restricted for service type.	The rendering provider is restricted for the product on the date of service specified.
24	Calculate Service Coordination Units	Using the start time and end time entered on the claim, calculate the total # of minutes for the claim. Assign units based on the total # of minutes as shown below: 0 – 5 minutes 0 units 6 -15 minutes 1 unit 16-30 minutes 2 units 31-45 minutes 3 units 46-60 minutes 4 units 61-75 minutes 5 units.

No.	Rule Name	Rule Description
25	Rendering Provider is subcontractor and has no basic agreement	Rendering provider is subcontractor and has a status<> Pending Agreement and does not have an active basic agreement.

Code Reference Table

The following table identifies the main system code responsible for implementing the business rules of this process.

Class	Method
EIS_ElectronicInvoice	process
EIS_ProcessElectronicInvoice	createInvoiceBatch renderingIsValid
EIS_MaintainProviderInvoiceBatch	submitInvoiceForBatchProcessing createProviderInvoiceBatch validateInvoiceDetails

Submit Invoice Process

Description: The Submit Invoice process executes the invoice business rules to determine whether a claim in an invoice is approved, denied or pended by the system. These business rules include NYEIS billing rules and the billing violation waiver rules.

Trigger: Invoices have been submitted by providers (manually via the screens in NYEIS or electronically). Any electronically submitted invoices have already been processed by the EIS_ElectronicInvoice batch process. The Submit Invoice process is a batch process scheduled to run at pre-determined times.

Output: System determines whether provider claim is approved, denied or pended. Provider invoice is reported in the MuniInvoiceReview work queue. For providers who are configured to submit claims electronically as of the claim date (and for the designated municipality), a record will be created in the EIS_STG_OUT_835_DENIED table for any claims that are denied. The iWay interface channels will then utilize the EIS_STG_OUT_835_DENIED records to report denied claims to providers on an 835 remittance file.

Business Rule Table

No.	Rule Name	Rule Description
1	Provider Claim Date of Service must be within Service Authorization Start and End Date	System validates provider claim against Service Authorization. Provider Claim Date of Service must be within Service Authorization Start and End Date. If not, the claim is denied.
2	Suspended or Removed SA	System validates provider claim against Service Authorization. If the Service Authorization has been Suspended or Removed, the claim is denied.
3	Visits/Service Authorization dollars ($) available	Visits/Service Authorization dollars ($) available on Service Authorization. If not, the claim is denied.

No.	Rule Name	Rule Description
4	Close Case Billing	Close Case Billing. Provider Claim Date of Service is within 1 year of Provider Claim Date Created. If not, the claim is denied. One year is a property (curam.custom.nyeis.claimDateLimit) that can be configured to a different time period.
5	Duplicate invoice	System validates this provider Invoice number is not a duplicate for the Provider of Record. If it is a duplicate, the claim is denied.
6	Duplicate claim	System validates Provider Claim number submitted by the Billing Provider is not a duplicate. If it is a duplicate, the claim is denied.
7	Rendering Provider Overlap	System validates rendering provider is not serving more than 1 child at the same time. If this validation fails, the claim is denied. Rule is bypassed for following reasons: • All of the related claims are for group products (5458, 5476, 5479, 5480, 5482, 5483, 5486, PN576, PN577, PN579, 5244, 5401, 5402, 5403, 5405, 5406, 5407, 5408, 5409, 5410, 5411, 5412, 5413, 5414, 5415, 5416, 5417, 5418, 5456) • If one and only one related claim is for Service Coordination • If the visits for related claims are co-visits
8	Provider restrictions	System checks for provider restrictions based on the service date and service type. If there are any restrictions, the claim is denied.
9	Service Start Date = Service End Date for GS claims	System validates that Service Start Date = Service End Date for Invoice Type = General. If not, the claim is denied.
10	Transportation Vendor & Transportation Caregiver Provider Claims have dollars available	System validates that Transportation Vendor & Transportation Caregiver Provider Claims have dollars available in Service Authorization. If not, the claim is denied.
11	Respite dollars remain	System validates that Respite dollars remain for this Respite Service Authorization. If not, the claim is denied.
12	Makeup Visits remain	If claim visit type = Makeup Visit, system validates Makeup Visits remain on Service Authorization. If not, the claim is denied.
13	Covisits remain	If claim visit type = Co-Visit, system validates Co-Visits remain on Service Authorization. If not, the claim is denied

No.	Rule Name	Rule Description
14	Child receiving service overlap	System validates child is not receiving service on different claims at the same time. If this validation fails, the claim is denied. Rule is bypassed for following reasons (9 minute overlap): • All of the related claims are for group products (5458, 5476, 5479, 5480, 5482, 5483, 5486, PN576, PN577, PN579, 5244, 5401, 5402, 5403, 5405, 5406, 5407, 5408, 5409, 5410, 5411, 5412, 5413, 5414, 5415, 5416, 5417, 5418, 5456) • If one and only one related claim is for Service Coordination If the visits for related claims are co-visits
15	Active contracts	System checks for active provider contracts. If there is no active contract, then deny the claim.
16	Valid service times for Service Coordination claims	System validates service times entered for Service Coordination claims to ensure they exist, don't overlap, and that the total time is at least 6 minutes. If not, the claim is denied.
17	Approved provider	System validates that the provider is approved as of the date of service. If not, the claim is denied.
18	CFY validation	System validates whether the supervisor associated with a submitted claim is the student/intern's supervisor on the date of service. If the supervisor is not the student/intern's supervisor on the date of the service, the claim will be denied.
For claims that were not denied by any of the previous validation rules, the system runs the following additional rules.		
19	Eval/general/and SC claims have claim lines	System will validate that eval/general/and SC claims have claim service lines.
20	ABA claims have at least 1 unit	The system will validate that ABA claims have at least 1 unit.
For claims that are GS claims and a visit type = Regular Visit, system runs billing violation rules. System first excludes all billing violations with an upfront waiver = approved and the SA on the provider claim on the billing violation that was approved. The remaining rules are then run comparing the provider claim and its service date vs. other provider claims that meet the billing violation criteria.		
21	Waiver rules for GS claims	For General Service claims, the system will run the waiver rules described in the section entitled "Upfront Billing Violation Process". See billing violation rules listed below:
22	Additional Invoice Billing Violations – Rule 16	IFSP Visits per Day Clinically Appropriate Exceeded
23	Additional Invoice Billing Violations – Rule 17	SA Visits per Day Clinically Appropriate Exceeded
For claims that pass all the rules above, the system calculates the approved claim amount as follows:		

No.	Rule Name	Rule Description
24	GS Claims and ABA Claims Rate Calculation	Using the product on the SA and service date on the claim, retrieve the rate for the product from the rate table.
25	Service Coordination Claims Calculation	Using the product on the SA and service date on the claim, retrieve the rate for the product from the rate table. Multiply this rate by the units on the claim.
26	Respite Claims Calculation	Use the # of hours entered on the claim and multiply by the Respite rate entered on the SA.
27	AT Device Claims Calculation	Approved Amount is calculated based on the Rate associated with DME Amount on the Service Authorization less any amounts paid by 3rd Party Insurance. The DME amount can be the DME rate amount selected on the SA or the Authorized Up to Amount.
28	Vendor Transportation Claims Calculation	If # of trips entered, multiply by the trip rate on the SA to calculate the approved amount. Otherwise, use the transportation amount entered on the claim.
29	Caregiver Public Transportation Claims Calculation	Use the receipt amount entered on the claim as the approved amount.
30	Caregiver Private Transportation Claims Calculation	If # of trips entered, multiply by the trip rate on the SA to calculate the approved amount. If # of miles entered, multiply by the mileage rate on the SA to calculate the approved amount.

Billing Violation Rules

Business Rule Table

No.	Rule Name	Rule Description
1	Rule1: No more than 3 Basic Home and Community Based Visits per Day	Check SA product with method of delivery of basic home/community-based indiv./coll visit for compliance with the rule.
2	Rule2: No more than 3 Extended Home and Community Based Visits per Day	Check SA product with method of delivery of extended home/community-based indiv./coll visit for compliance with the rule.
3	Rule3: No more than 1 Basic Home and Community Based Visit per Discipline per Day	Check SA product with method of delivery of basic home/community-based indiv./coll visit and QP on SA for compliance with the rule.
4	Rule4: No more than 1 Extended Home and Community Based Visit per Discipline per Day	Check SA product with method of delivery of extended home/community-based indiv./coll visit and QP on SA for compliance with the rule.

No.	Rule Name	Rule Description
5	Rule5: No more than 3 Basic and Extended Home and Community Based Visits per Day	Check SA product with method of delivery of basic or extended home/community-based indiv./coll visit for compliance with the rule..
6	Rule6: No Basic and Extended Home and Community Based Visits within the Same Discipline per Day	Check SA product with method of delivery of extended home/community-based indiv./coll visit and another with method of delivery of basic home/community-based indiv./coll visit and the same QP on the SA for compliance with the rule..
7	Rule7: No more than 1 Office/Facility Visit per Discipline per Day	Check SA product with method of delivery of Office/Facility Indiv/Coll Visit and QP on SA for compliance with the rule..
8	Rule8: No more than 3 Office/Facility Based Visits per Day	Check SA product with method of delivery of Office/Facility Indiv/Coll Visit for compliance with the rule.
9	Rule9: No more than 1 Parent/Child Group Visit per Day	Check SA product with method of delivery of Parent/Child for compliance with the rule.
10	Rule10: No more than 2 Family/Caregiver Support Group Visits per Day	Check SA product with method of delivery of Family Caregiver Support Group for compliance with the rule.
11	Rule11: No more than 1 Group Developmental Visit per Day	Check SA product that are Group Developmental for compliance with the rule. Group Developmental Includes the following products: Basic Group Developmental Enhanced Group Developmental Basic Group Developmental w/ 1:1 Aide Enhanced Group Developmental w/ 1:1 Aide
15	Rule15: No more than 2 Additional Supplemental Evaluations during a 1 Year Period	Check SA product with method of delivery of Supplemental Evaluation for compliance with the rule.