



## New York State Medicaid Ambulatory Patient Group (APG) Billing for OASAS Certified Outpatient Programs Including:

- Clinic;
- Rehabilitation;
- Youth; and,
- Opiate Treatment

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# Why APGs?

## Federal and State Perspective / Benefit

### Federal Needs: APGS Support:

- Federal directive to ensure that individual State's Medicaid claiming process are compliant with overall HIPPA claim formats
- Increased Federal interest in State's development of Medicaid pricing schema that provide greater clarity and transparency of Medicaid payment structure and methodology

### State Needs: APGS support:

- State's ability to respond to Federal needs listed above
- Support key component of New York State's overall effort to reform Medicaid reimbursement and rationalize service delivery. This includes encouraging migration of services from inpatient to ambulatory/primary care settings



# Why APGs?

## OASAS Perspective Clinical and Payment Benefits

- Supports movement by the addictions field towards one outpatient system of care.
- Allows for a range of medically necessary clinic services for patients based on the evidence of what works to promote recovery from chemical dependency.
- Replace the current threshold visit reimbursement system for OASAS certified programs. The threshold system: paid clinics one service / day); and, opiate treatment programs one weekly payment regardless of the resources needed to deliver unique services or the number of services provided.
- Pays for multiple services on same visit date
- Provides Medicaid reimbursement for some chemical dependence services that were not previously billable e.g. complex care coordination
- Allows for some services that are integral to the treatment of patients in chemical dependency treatment such as mental and physical health services.



# APG Development Process

- DOH led a multi-agency effort that included OASAS, OMRDD, and OMH.
- APGs are part of an overall State goal to transition Medicaid payment for most physical and behavioral health outpatient services from the current threshold prices to a cost based pricing structure.
- APGs support disaggregation of the current Medicaid threshold rates and services categories into discrete service categories and payment levels that more accurately define services and reflect Medicaid reimbursable costs associated with delivering a particular service.
- In the OASAS system, APGs will apply to OASAS certified Part 822, Part 823, and Part 828 Programs.



# Background

- Prior to APG Implementation the Medicaid reimbursement system for OASAS ambulatory service (outpatient and methadone) clinics utilized a rate based threshold visit payment that supported one service claim per day (Part 822 or Part 823) or one claim weekly (Part 828) regardless of the number or type of services provided in a visit.
- Under APG programs will have access to 15 APG service categories that will be claimed using a combination of APG rate codes and designated HCPCS / CPT codes.



# How Were the APG Billing Service Categories Developed?

- Identified services that occur in outpatient substance abuse settings.
- Compared with OMH and OPWDD partners – where shared services APGs will have shared weight.
- Compared to National Coding Systems (HCPCS/CPT).
- Regional Forums with Providers to gather input on service categories.



OASAS APG Service Map		
Service	Service	Service
Screening/Brief Intervention or Treatment	Individual Brief	Medication Administration
Assessment Brief	Individual Normative	Medication Management Routine
Assessment Norm	Group	Medication Management Complex
Assessment Extended	Family Collateral	Peer Counseling
Intensive Outpatient	Complex Care	Outreach
Outpatient Rehabilitation	Physical Health Services – guidance under development	



# **OASAS APG Medicaid Billing Process and Rules**





- **Upon conversion to the APG payment structure, the former OASAS threshold rate codes will be eliminated and providers must bill Medicaid using the CPT / HCPCS codes and the related OASAS APG Rate Code.**
- **All OASAS APG rate, CPT, and HCPCS codes are listed in the online OASAS APG Clinical and Medicaid Billing manual at:**

<http://www.oasas.ny.gov/admin/hcf/APG/Index.cfm#CLINICALANDBILLINGMANUAL>



# Former Medicaid Billing

## OASAS Service Categories Pre and Post APGS

### Pre APG Medicaid Billing / Service Categories:

- Outpatient Clinic – Three daily billing service categories (Assessment; Individual and Group) and a single daily Medicaid payment:
- Opiate Treatment Clinic - One weekly claim and a single weekly payment for the entire episode of care and all services delivered in that week

### Post APG Medicaid Billing / Service Categories:

- All Programs will have 15 different service categories available for use when billing Medicaid (see slide eight for all categories).



### OASAS APG Rate Codes For Hospital Based Programs

<u>Chemical Dependence Services</u>	OASAS APG RATE CODE	Former Medicaid Rate Code
Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Clinic Program	1528 Visit Code	4273 Assessment 4274 Individual 4275 Group
Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Rehab Program	1528 Visit Code	4276 Assessment 4277 Full Day / 4 hours 4278 Half Day 2-4 hours
Part 822 Hospital (Art 28 and Art 32) Outpatient Youth Programs	1528 Visit Code	4283 Assessment 4284 Individual 4285 Group
Part 822 Hospital (Art 28 and Art 32) Opiate Treatment Program	1531 Episode Code	2973 Weekly Visit



### OASAS APG Rate Codes For Non Hospital Programs

<u>Chemical Dependence Services</u>	APG RATE CODE	Former Medicaid Rate Code
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Clinic Program	1540 Visit Code	4214 Assessment 4215 Individual 4216 Group
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Rehab Program	1540 Visit Code	4217 Assessment 4218 Full Day / 4 hours 4219 Half Day 2-4 hours
Part 822 Community (Art 32 only) Outpatient Youth Programs	1540 Visit Code	4280 Assessment 4281 Individual 4282 Group
Part 822 Community (Art 32 only) Opiate Treatment Program	1543 Episode Code	1671 Weekly Visit



## OASAS APG HCPCS /CPT (continued on next slide)

The service definitions and associated CPT or HCPCS codes listed in this manual are for the purposes of billing the New York State Medicaid program. It is recognized that in some instances the OASAS service definition and applicable CPT or HCPCS codes may vary from: the service definition listed in the CPT or HCPCS manuals; and/or, be different from codes they are used with commercial or Medicare billing. Programs should use the codes as listed in this manual for billing the New York State Medicaid program, and then use Medicare or commercial coding as indicated by the relevant billing / coding guidelines.

APG Category	HCPCS / CPT CODE	APG Category	HCPCS /CPT CODE
Screening ,  Brief Intervention Brief Treatment 15 minute minimum	H0049  H0050	Individual Counseling Brief 25 minute minimum	G0396 Alcohol and / or Substance Abuse
Medication Administration and Observation	H0020 – Methadone H0033 - Oral Medication 96739 - unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion.	Individual Counseling Normative 45 minute minimum	G0397 Alcohol and / or Substance Abuse
Medication Management Routine 15 minute minimum	H0034 Medication Training and support M0064 Visit for Drug Monitoring	Group Counseling 60-90 minutes	90849 Multiple Family – only for use with adolescent family collateral group session. H0005 Alcohol and/or drug services
Medication Management Complex 30 minute minimum	90862 Medication Management	Collateral Visit 30 minute minimum	T1006 Family / Couple Counseling – occurs w/o patient present



## OASAS APG HCPCS /CPT (continued )

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APG Category	HCPCS / CPT CODE	APG Category	HCPCS /CPT CODE
Assessment Brief 15 Minute Minimum	T1023 To determine the appropriateness of an individuals participation in a specific program	Complex Care Coordination 45 minute minimum	90882 Environmental intervention for medical Management purpose on a psychiatric patient's behalf with agencies, employers, or institutions.
Assessment Normative – 30 minute minimum	H0001 – Alcohol and/or drug assessment	Peer Counseling 30 minute minimum	H0038 – Peer Services
Assessment Extended 75 minute minimum	H0002 – Behavioral Health Screening to determine eligibility for admission	Outpatient Rehabilitation	H2001- 2- 4 hour duration  H2036 - 4 hour and above service duration
Intensive Out Program	S9480 – Intensive Outpatient psychiatric services , per diem		



# Discounting

- When a patient receives more than one service / procedure on a single visit date, the highest value service / procedure shall be paid at its full APG fee value.
- Payments for the second procedures / service will be discounted by 10%. The discount is applied to the APG payment portion of the claim. E.g. If a patient receives an individual and group service on the same visit date, the group APG payment would discount by 10%.
- Generally, no more than two different services will be paid for on a single service date. And in no case can the program receive payment for two of the same service types delivered on the same day. E.g. Two individuals will not be paid.
- However, the following services are exempt from the above two billable service rule: complex care coordination; medication administration; medication management; and, peer support services. E.g. an individual, group and medication management may be claimed on the same visit date and the program would receive reimbursement for all three service, with the group service payment discounted by 10%.



# Outpatient Clinic Billing Components

- Under APGs, programs will now be able to submit one visit claim per patient per day of service AND that claim will reflect multiple services lines.
- However, Medicaid APG billing is generally limited to no more than two different services per visit date. For example, a program may bill and receive reimbursement for a group and an individual service on the same visit date, but may not bill for two individual services on the same visit date.
- The claim will correspond with the actual service visit date and the multiple lines will represent all the services delivered on one day.



# Opiate Treatment Program (OTP) Billing Components

- OTP claims will be submitted using a weekly episode of care construct. As with the prior weekly threshold claims process, under APGS one weekly episode claim per opiate patient will be submitted.
- Under APGS the episode defined as the calendar week (Mon – Sun) and the OTP billing submission date should reflect the Sunday that closed that weekly episode.
  - Example: If the episode dates of service were Monday October 4, 2010 through Sunday, October 10, the claim submission date would be Sunday, October 10. The From / Thru date on the claim would be Monday, October 4, 2010 through Sunday, October 10, 2010.
- However, under APGS the single episode claim will potentially include multiple CPT or HCPCS codes and discrete visit dates to reflect the services that are delivered on the individual days encased within the episode.



# Opiate Episode Specific Claiming Information

## **Question: Edit 00743**

Historically, there was a Sunday Date of Service (DOS) edit, 00743 that denied claims that did not have a Sunday from date of service. Will this edit continue under APGs?

## **Answer:**

Under AGPS this edit is not set to deny for weekly opiate claims but the expectation is that the claim submission will still reflect a Sunday date.



# Opiate Episode Specific Claiming Information

## **QUESTION: Service Visit Dates**

Does the opiate episode claim have to reflect each individual date of service, with the discrete HCPCS / CPT service codes listed for each date?

## **ANSWER:**

Yes, even though the OTP claim will be using a weekly episode logic the claim will still need to reflect the individual dates of service. Each procedure, with its specific date must be reported on the episode claim. Payment will be based upon a single percentage applied to the former weekly opiate threshold rate plus a percentage of the APG service payment rate.

## **QUESTION: Calculating the Episode Payment.**

How will the Medicaid System Calculate the payment for all services encompassed within the Opiate Episode Claim? Will the remittance / payment be one single payment that reflects the individual services delivered within the episode?

## **ANSWER:**

The episode payment will be equal to the sum of the lines, by visit date, that are encompassed within the episode. This calculation will be done by the Medicaid system and take place at the State level.



# APGs and Transportation Claims for NYC Opiate treatment programs patients

- The APG claiming applies only to counseling / treatment services.
- The APG exercise should not have an impact on, or require a change in the process the program currently uses for submitting transportation claims for NYC opiate treatment patients.
- For example, if when generating an 837 EDI service claim file, the program / vendor currently appends a separate transportation claim, the program / vendor may continue that process.



# Outpatient Clinical and Billing: Sample

	Monday – Hospital APG Visit Code 1528		Tuesday – Hospital APG Visit Code 1528		Wednesday -Hospital APG Visit Code 1528		Friday -Hospital APG Visit Code 1528	
W e e k  O n e	Service	Code	Service	Code	Service	Code	Service	Code
	Assessment Extended	H0002	Assess Brief	T1023	Individual Normative 45 mins	G0397	Multi- family Group - Collateral visit	90849
	Collateral Contact	T1006			Collateral Contact	T1006		
					Group	Do not bill, this is not an exempt third service		



# Clinical and Billing Sample:

OTP Sample from a hospital owned / operated opiate treatment program

A single episode claim, submitted on Sunday using the 1531 Hospital Episode Rate Code; the discrete visit date; and the HCPCS / CPT that corresponds to the discrete visit date.

Monday xx/xx/xxxx	Tuesday xx/xx/xxxx	Wednesday xx/xx/xxxx	Thursday xx/xx/xxxx	Friday xx/xx/xxxx	Saturday xx/xx/xxxx	Sunday xx/xx/xxxx
	Assessment Extended <b>CODE H0002</b>  Medication Management Complex <b>CODE 90862</b>  Medication Administration <b>CODE H0020</b>	Medication Administration <b>CODE H0020</b>  Individual Brief 25 mins <b>CODE G0396</b>	Medication Administration <b>CODE H0020</b>	Medication Administration <b>CODE H0020</b>	Medication Administration <b>CODE H0020</b>	Submit Claim



# APG Medicaid Payment Phase-In

Phase	Current Threshold Legacy Payment (Legacy = pre-APG Medicaid payment amount)	APG Payment
Phase 1	75% Freestanding Programs Start at Phase 1	25% of the full APG Payment
Phase 2	50% Hospital Programs Start at Phase 2	50% of the full APG Payment
Phase 3	25%	75% of the Full APG payment
Phase 4	0	100% of the full APG Payment



# Billing Rules Summary

Providers MUST use the APG rate codes and designated HCPCS / CPT codes

Per OASAS regulation, Medicaid APG billing is generally limited to no more than two different services per visit date. However, the following APG services may be billed in addition to the two APG services per visit date limit and will pay at full price:

- Medication Administration
- Medication Management (Routine and Complex)
- Complex Care Coordination
- Peer Services

Two of the same APG services may not be billed in on the same visit date, e.g. a brief individual and an extended individual may not be billed on the same day.

If two APG services are billed on the same visit date, then the lower weighted (priced) APG service will be discounted by 10%. The Medicaid system will calculate the discount.

The following APG services are exempt from the 10% discount rule and will pay at their full rate:

- Medication Administration
- Medication Management (Routine and Complex)
- Complex Care Coordination
- Peer Services
- All other APG services will discount when provided with a higher weighted APG service.



# **Computer Sciences Corporation (CSC) OASAS APG Medicaid Billing Information**



# Provider Billing Changes

- New Rate Codes Effective XX/XX/20XX Dates of Service
- New APG Grouper Access Rate Codes: OASAS codes are by peer group and provider type.
- Most current Rate Codes will become obsolete as of APG effective date
- For billing or adjusting dates of service prior to APG implementation use old rate code
- Essentially, the minimum billing change required to bill Medicaid and get paid under APGs is to:
  - use the new APG rate code rather than one of the existing rate codes; and,
  - the correct CPT or HCPCS code.



# Provider Billing Changes (cont.)

- Code and Bill to Medical Record Documentation:
  - Complete and accurate reporting
  - Procedure and diagnosis code(s)
- All services within the same DOS and rate code (or Episode if Opiate Treatment Program rate code) must be billed together on a single claim.
  - If two claims are submitted, with the same rate code for the same DOS, only the first claim submitted will pay. The second will be denied.



# Provider Billing Changes (cont.)

## Managed Care OASAS Service Carve Outs:

- OASAS certified outpatient clinic and Opiate treatment services continue to be carved out of the Medicaid managed care benefit package.
- The Managed Care Scope of Benefits File will be updated to include the OASAS APG rate codes.
- This update will allow programs to continue to bill straight Medicaid for OASAS outpatient services, and if correctly coded the claim will not hit edit 1172 “Prepaid Cap Recipient Service Covered By Plan”



# Editing Reminder for Hospital Based Programs

- MMIS Edit 1136:
  - Rate Code invalid for clinic (Do not submit add-on rate code on claim)
- HIPAA835/277 Mapping:
  - Adjustment Reason Code 16: Claim/Service lacks information which is needed for adjudication
  - Remit Remark Code M49: Missing/incomplete/invalid value code(s) or amount(s)
  - Status Code: 463: NUBC value code(s) and/or amount(s)



# Editing Changes (cont.)

- MMIS Edit 2001:
  - Prior payer paid amounts Claim Header and Line Payments must balance
  - See 837 COB Tutorials for example of balancing:
    - [http://www.emedny.org/hipaa/FAQs/837\\_COB\\_Tutorial\\_2.html](http://www.emedny.org/hipaa/FAQs/837_COB_Tutorial_2.html)
    - [http://www.emedny.org/hipaa/FAQs/837\\_COB\\_Tutorial\\_1.html](http://www.emedny.org/hipaa/FAQs/837_COB_Tutorial_1.html)
- HIPAA 835/277 Mapping:
  - Adjustment Reason Code 125: Payment adjusted due to a submission/billing error(s)
  - Remit Remark Code N4: Missing/incomplete/invalid prior insurance carrier EOB
  - Status Code 400: Claim is out of balance



# Editing Changes (cont.)

- MMIS Edit 2081
  - All APG claim lines paid zero
  - Ungroupable lines
  - Paid zero lines
- HIPAA 835/277 Mapping
  - Adjustment Reason Code 125: Payment adjusted due to a submission/billing error(s)
  - Remit Remark Code N19: Procedure incidental to primary procedure
  - Status Category Code: F1: Finalized/Payment. The claim line has been paid
  - Claim Status Code: 65: Claim Line Has Been Paid



# Processing Changes

- Allocating Medicare/Other Insurance
  - Deductible, coinsurance, co-pays
  - If only reported at header of claim
  - Amounts from header allocated to lines
    1. Sum of APG payments for all lines
    2. Individual line payments divided by Sum of all line payments = line percentage
    3. Header Amounts allocated to each line by percentage



# Processing Changes (cont.)

- Bundling Other Insurance Information for zero paid lines:
  - Reported payments, deductible, coinsurance and/or co-pays
  - Amounts moved to line with highest adjusted weight for zero paid line



# Medicare Crossover Reminders

- Medicare Parts A & B will crossover claims directly from Medicare's Coordination of Benefits Contractor (COBC) to NY Medicaid for payment of the Medicare Patient Responsibilities (PR's)
- If the procedure code billed to Medicare differs from the procedure code usually billed to Medicaid the claim will still crossover and pay.
- Important: The NPI on the claim submitted to Medicare **must** be the NPI enrolled with NY Medicaid
- If Medicare denied the claim it will **not** be crossed over to Medicaid
- OASAS will be providing coding guidance for Medicare claims and this guidance may be found in the online OASAS APG clinical and billing guidance manual.

<http://www.oasas.ny.gov/admin/hcf/APG/Index.cfm#CLINICALANDBILLINGMANUAL>



# Medicare Crossover Reminders

- If the COBC crossover claim is paid and a provider then submits a separate crossover claim to eMedNY, the provider submitted claim will be denied as a duplicate claim
- If a provider submits a claim before the crossover claim, both the provider submitted claim and the crossover claim will be paid
  - The eMedNY system will subsequently & automatically void the provider submitted claim



# Remittance Changes

- 835 Supplemental files will contain line level detail
- Line Level processing of APG claims
  - Line level COB
  - Line level detail included in remittances
- 835 Changes
  - Line level detail
  - New data elements
  - Bundling



# Remittance Changes (cont.)

- New 835 Remittance Data in Loop 2110
  - APG Code – REF02 (Qualifier 1S)
  - APG Full Weight – QTY02 (Qualifier ZK)
  - APG Allowed Percentage – QTY02 (Qualifier ZL)
  - APG Paid Amount – AMT02 (Qualifier ZK)
  - Existing Operating Amount – AMT02 (Qualifier ZL)
  - Combined With CPT – SVC06-2 (Qualifier HC)
  - Line Number – REF02 (Qualifier 6R)
  - CPT – SVC01-3 (Qualifier HC)
  - Capital Add-on amount – CAS CO94
  - Zero paid line (amounts bundled to highest weight line) – CAS CO97
  - Bundled line amount added to the highest weight line – CAS OA94
  - Total payment for claim – CLP04



# Remittance Changes (cont.)

- Paper remittance example
  - Total paid TCN above line payments
  - New data elements indented for easier reading





MEDICAL ASSISTANCE (TITLE XIX) PROGRAM  
REMITTANCE STATEMENT

PAGE 02  
DATE 12/19/2008  
CYCLE 1635

TO: ABC HOSPITAL  
P.O. BOX 999  
ANYTOWN, NEW YORK 11111

ETIN:  
CLINIC-APG  
PROVIDER ID/NPI: 00987654/0123456789  
REMITTANCE NO: 08122200001

OFFICE ACCOUNT NUMBER CPT	CLIENT NAME APG	CLIENT ID COMBINED WITH CPT	TCN FULL WEIGHT APG AMOUNT	DATE OF SERVICE PCT APG WEIGHT	RATE CODE APG PAID	CHARGED CAPITAL ADD ON	TOTAL PAID EXISTING OPERATING COMPONENT	STATUS	ERRORS
1	2	3	4	5	6	7	8		
<p>TCN: 08343-000789012-2-0 TOTAL PAID: 185.50</p>									
1234567890 99213	Bill Smith 00881	AB12345C	08343-0007890 12-2-0 1.22020	12/01/2008 100	1400 45.25	1000.00 15.00	106.02 48.77	PAID	
1234567890 85025	Bill Smith 00408	AB12345C 99213	08343-0007890 12-2-0 0.13340	12/01/2008 0	0.00	800.00 0.00	0.00 0.00	PAID	
1234567890 80076	Bill Smith 00403	AB12345C	08343-0007890 12-2-0 0.32690	12/01/2008 100	12.00	1000.00 0.00	24.94 12.94	PAID	
1234567890 90740	Bill Smith 00416	AB12345C	08343-0007890 12-2-0 0.44200	12/01/2008 100	16.25	200.00 0.00	33.77 17.52	PAID	
1234567890 36415	Bill Smith 00457	AB12345C	08343-0007890 12-2-0 0.26740	12/01/2008 100	10.00	50.00 0.00	20.77 10.77		

The paid amount for the first claim is determined by the sum of the APG Paid \$83.50 (The amounts in column 6 already reduced to 25% in year 1), plus the sum of the Existing Operating Component \$90.00 (The amounts in column 8 that are already reduced to 75% for year 1), plus the Capital Add-on amount in column 7, \$15.00, plus any reductions. = Total Paid TCN \$185.50.

NEW APG DATA ELEMENTS:

1. CPT: Reported procedure code
2. APG: APG code assigned by grouper
3. Combined With CPT: Pointer to other significant procedure that caused the packaging and therefore zero payment on this line
4. Full Weight APG Amount: Assigned grouper weight
5. PCT APG Weight: Related to grouper assigned Payment Action Code. This is additional weight factor applied to Full Weight
6. APG Paid: APG Paid Amount for outpatient is the amount after the 25%, 50% or 75% is applied over each of the first three years.
7. Capital Add-on: Amount added to Claim Payment (line 1).
8. Existing Operating Component: Amount added to outpatient payments after the 75%, 50%, 25% is applied over each of the first 3 years and disbursed over paid lines.
  - a. Figure above EOC -Total line payment - includes reductions for Medicaid co-payments, reported or prorated/bundled other insurance payments and prorated spend downs, if any. Total line payments will equal Total TCN paid amount.
9. Total Paid TCN: Total Claim Payment
10. Rate Code: Will appear only on line 1 of claim

# Provider Testing Environment (PTE)

- Test Environment Available 24X7
- Test Environment will support the following transactions:
  - 270/271 Eligibility
  - 276/277 Claim Status
  - 278 PA & Service Authorizations
  - 835 Remittance Advice
  - 837 Claims (Institutional, Professional, Dental)



# Provider Testing Environment (PTE) (Cont.)

- Test Submissions
  - Providers can submit up to 50 claims per test file (50 CLM Segments)
  - Unlimited number of files can be submitted
  - Test files submitted and retrieved through providers' production communication method (same FTP/eXchange mailbox)
  - Test indicator on incoming file "T" ISA15



# Provider Testing Environment (PTE )

(cont.)

- Test Remit Delivery
  - Test Remit delivered in providers' production method (eXchange, iFTP, Paper or FTP)
  - Deliver providers' production remit type (paper/835 + Supplemental)
  - Weekly Test cycle close Fridays 2 PM
  - Remits delivered weekly for sum of all test claims submitted for that week by following Monday
  - Test indicator "T" ISA15
  - 835 Supplemental remit file names "T", but more importantly high **cycle #**
    - eXchange example: R090117032413.**8641**.835-.tar (no "T" on the TAR)
    - R090117032412.**8641**.835-.T.00.x12
    - FTP example: R090123223001.**8642**.835-.T.00
  - Paper remits "Test" has watermark on each page



# Provider Testing Environment (PTE)

(cont.)

- No History editing
  - No capability to do adjustments
- No Edits that pend a claim
- No Edits for PA and Service Auths.



# Contact Information

- Grouper/Pricer Software Support
  - 3-M Health Information Systems, Inc.
  - Grouper / Pricer Issues 1-800-367-2447
  - Product Support 1-800-435-7776
  - <http://www.3mhis.com>
- Billing Questions
  - Computer Sciences Corporation
  - eMedNYCall Center 1-800-343-9000
  - <http://eMedNYProviderRelations@csc.com>
- OASAS Policy and Rate Issues: Please see:
  - <http://www.oasas.ny.gov/admin/hcf/APG/Index.cfm>

