New York Medicaid Program

29-I Health Facility

BILLING GUIDANCE

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SECTION 1: GENERAL

The purpose of this manual is to provide billing information regarding services provided by 29-I Licensed Health Facilities and administered by the New York State Department of Health (NYS DOH) and Office of Children and Family Services (OCFS). This manual applies to services covered by both Medicaid Managed Care (MMC) and Medicaid fee-for-service (FFS) and outlines the claiming requirements necessary to ensure proper claim submission for services delivered by a 29-I Health Facility. This manual is intended for use by both Medicaid Managed Care Plans (MMCP) and 29-I Health Facilities.

This manual provides billing guidance only. It does not supersede applicable regulatory requirements or procedures for admission to a program, record keeping, service documentation, initial and on-going treatment planning, and reviews, etc. The contents of this manual may be subject to change as required.

Voluntary Foster Care Agencies (VFCAs) that have not obtained 29-I licensure are NOT authorized to provide and/or bill for health care services outlined in this guidance. All VFCAs that are licensed as 29-I Health Facilities will have a NYS DOH issued license indicating authorization to bill for Core Limited Health-Related Services and Other Limited Health-Related Services. This manual does NOT provide guidance regarding Maximum State Aid Rates (MSAR) payments. MSAR information and guidance can be found at https://ocfs.ny.gov/main/rates/assets/docs/SOP-Program-Manual.pdf

SECTION 2: FUNDAMENTAL REQUIREMENTS

2.1 ARTICLE 29-I LICENSED SERVICES

VFCAs serving principally as facilities for the care of and/or boarding out of children shall be subject to the provisions of Article 29-I of the Public Health Law (PHL) and applicable state and federal laws, rules, and regulations. While 29-I licensure is optional, VFCAs are required to obtain and maintain 29-I licensure to bill eMedNY and MMCPs for the services listed in this document.

There are two categories of services that can be provided within 29-I Health Facilities: Core Limited Health-Related Services (Mandatory) and Other Limited Health-Related Services (Optional). 29-I Health Facilities must provide all Core Limited Health-Related Services. The Core Limited Health-Related Services as described in this schedule, and the associated billing, are available only to children/youth in the care of a 29-I Health Facility.

Pursuant to Article 29-I of Section 1 of the Public Health Law (PHL), VFCAs must be licensed for the provision of Core Limited Health-Related Services and Other Limited Health-Related

Services as described above to contract with and bill MMCPs and comply with Corporate Practice of Medicine standards.

To become licensed as a 29-I Health Facility, the providers must submit an application to OCFS and DOH, which indicates the location and describes the physical environment where each of the Core Limited Health-Related Services and any Other Limited Health-Related Services will be provided. In addition, the application must demonstrate compliance with all required rules and regulations. Additional information regarding Core Limited Health-Related Services, Other Limited Health-Related Services, and 29-I licensing requirements can be found at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_vfca_health_facilities_license_guidelines.pdf

2.2 MEDICAID-ENROLLED PROVIDER

All eligible health care providers are required to enroll in Medicaid in order to receive reimbursement for delivering a Medicaid service.

29-I Health Facilities must be enrolled with category of service code **0121** to bill for Core Limited Health-Related Services, and category of service code **0268** to bill for Other Limited Health-Related Services.

Information on how to become a Medicaid provider is available on the eMedNY website: https://www.emedny.org/info/providerenrollment/

2.3 MEDICAID MANAGED CARE CONTRACTING

To be paid for services delivered to a child/youth enrolled in a Medicaid Managed Care Plan, a provider must be contracted and credentialed with that MMCP for the service rendered (i.e. in the MMCP's network). Plans must enter into Single Case Agreements (SCAs), if needed, to facilitate payment to a 29-I Health Facility who has not contracted with the MMCP and will deliver services to a child/youth. More information on Medicaid Managed Care contracting can be found in the Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care.

2.4 PROVIDERS DESIGNATED TO DELIVER CFTSS AND CHILDREN'S HCBS SERVICES

29-I Health Facilities may provide Children and Family Treatment and Support Services (CFTSS) and Children's Home and Community Based Services (HCBS) as part of their Other Limited Health-Related Services. 29-I Health Facilities who wish to provide CFTSS and HCBS are required to receive the appropriate designation(s) from the State.

Additional information can be found on the NYS Children's Behavioral Health System Transformation webpages:

- Children and Family Treatment Supports and Services (CFTSS) https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm
- Home and Community Based Services (HCBS) https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm
- Provider Designation for HCBS and CFTSS https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm

SECTION 3: SERVICES AND RATES

3.1 CORE LIMITED HEALTH-RELATED SERVICES (MANDATORY FOR ALL 29-I HEALTH FACILITIES TO PROVIDE)

All Licensed Article 29-I Health Facilities are required to provide, or make available through a contract arrangement, all Core Limited Health-Related Services. The five Core Limited Health-Related Services play a vital role in assuring all necessary services are provided in the specified time frames; children, parents and caregivers are involved in the planning and support of treatment, as applicable; information is shared appropriately among professionals involved in the child's care; and all health-related information and documentation results in a comprehensive, person-centered treatment plan. Medical necessity must be documented, as referenced in Appendix A, and in accordance with the 29-I Health Facilities Licensing Guidelines available at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_vfca_health_facilities_license_guidelines.pdf

The five Core Limited Health-Related Services are listed below (detailed in the *Article 29-I VFCA Health Facilities License Guidelines*):

1. Skill Building (provided by Licensed Behavioral Health Practitioners (LBHPs) as described in *Article 29-I VFCA Health Facilities License Guidelines* and any subsequent updates)
2. Nursing Services
3. Medicaid Treatment Planning and Discharge Planning
4. Clinical Consultation/Supervision Services
5. VFCA Medicaid Managed Care Liaison/Administrator

3.2 CORE LIMITED HEALTH-RELATED SERVICES RATES (MEDICAID RESIDUAL PER DIEM)

The Medicaid residual per diem rate reimburses 29-I Health Facilities for Core Limited Health-Related Services and is associated with the 29-I facility type (see *Table 1: 29-I Health Facility Types*) and indicated on the Article 29-I License. All 29-I Health Facilities are required to provide the Core Limited Health-Related Services to all children residing in the facility. Services are standardized across each facility type and are reimbursed based on a standardized Medicaid residual per diem rate schedule. Core Limited Health-Related Services (Medicaid per diem) rates can be found at https://www.health.ny.gov/facilities/long_term_care/reimbursement/cfc/2021-24_foster_care_rates.htm

Core Limited Health-Related Services are reimbursed with a Medicaid residual per diem rate paid to 29-I Health Facilities on a per child/per day basis to cover the costs of these services. For children/youth not enrolled in a plan, providers must bill Medicaid Fee-for service (FFS) via eMedNY. For members who are enrolled in a managed care plan, providers must bill the MMCP. The MMCP will bill the State for the per diem as pass through for the four-year transition period. At the end of the transition period, the State will reassess progress of the implementation and determine if transitional requirements should be extended.

Article 29-I of the PHL indicates which level(s) of care are provided by each 29-I Health Facility. 29-I Health Facilities are categorized by the level of care provided, as outlined in *Table 1: 29-I Health Facility Types*. Core Limited Health-Related Services (Medicaid residual per diem) rates differ based on both the level of care and the facility type the 29-I Health Facility is operating, with one rate assigned to each of the 13 facility types. Since a 29-I Health Facility may operate more than one facility type in one or more levels of care, it may be necessary for a 29-I Health Facility to bill several different Core Limited Health-Related Services (Medicaid per diem) rates, depending on how many facility types that 29-I Health Facility operates. The Core Limited Health-Related Services (Medicaid per diem) rate billed must correspond to the rate for the facility type the individual child/youth is residing in. However, only one Core Limited Health-Related Services (Medicaid per diem) rate per day for each individual child/youth can be billed. The Medicaid residual per diem rate is paid for the duration of the child's stay in the 29-I Health Facility; there are no annual or monthly limits applied to the per diem rate. There are four (4) levels of care, which are identified in the table below:

Table 1: 29-I Health Facility Types

Level	Description	Facility Type
Level 1	General Treatment	• Foster Boarding Home
Level 2	Specialized Treatment	• Therapeutic Boarding Home (TBH)/AIDS • Medically Fragile (former Border Babies) • Special Needs
Level 3	Congregate Care	• Maternity • Group Home (GH) • Agency Operated Boarding Home (ABH) • Supervised Independent Living Program (SILP)
Level 4	Specialized Congregate Care	• Group Residence (GR) • Diagnostic • Institutional • Hard to Place / Other Congregate • Raise the Age

29-I Health Facilities are reimbursed to provide the Core Limited Health-Related Services under the Article 29-I licensure through the Medicaid residual per diem, which are paid by MMCPs to the 29-I Health Facility (or Fee-For-Service Medicaid for those children not enrolled in Managed Care).

Refer to Appendix B for a list of the 13 Core Limited Health-Related Services rate codes that correspond to the level and facility type.

3.3 CORE LIMITED HEALTH-RELATED SERVICES RATES FOR STEP DOWN AGENCIES

Transitional rates will be updated yearly beginning July 1, 2021 through July 1, 2024. On July 1, 2024, all 29-I Health Facilities will be reimbursed the standard rate schedule based on facility type. For 29-I Health Facilities that are receiving a transitional rate for Core Limited Health-Related Services, rates will be specific to the facility type that is transitioning with a unique agency-based rate.

3.4 OTHER LIMITED HEALTH-RELATED SERVICES (OPTIONAL SERVICES A 29-I HEALTH FACILITY MAY PROVIDE)

The Other Limited Health-Related Services that can be provided by a 29-I Health Facility to meet a child/youth's individualized treatment goals and health needs are listed below. Other Limited Health-Related Services a 29-I Health Facility provides must be included on the 29-I License prior to delivery of services except for CFTSS and HCBS, which require a separate State designation and are indicated in the 29-I's NYS Designation letter. This manual does not address service components, prior authorization, or other guidance on Children's HCBS and CFTSS and does not change those processes.

Children's Home and Community Based Services Manual can be found here:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_manual.pdf

Children and Family Treatment and Support Services Provider Manual for EPSDT Services can be found here:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf

1. Children and Family Treatment Supports and Services (CFTSS)
    a. Other Licensed Practitioners (OLP)
    b. Community Psychiatric Supports and Treatment (CPST)
    c. Psychosocial Rehabilitation (PSR)
    d. Family Peer Supports and Services (FPSS)
    e. Youth Peer Support and Training (YPST)
    f. Crisis Intervention (CI)

2. Children's Waiver Home and Community-Based Services (HCBS)
    a. Caregiver Family Advocacy and Support Services
    b. Respite (Planned and Crisis)
    c. Prevocational Services
    d. Supported Employment
    e. Day Habilitation
    f. Community Habilitation
    g. Palliative Care: Counseling and Support Services
    h. Palliative Care: Expressive Therapy
    i. Palliative Care: Massage Therapy
    j. Palliative Care: Pain and Symptom Management
    k. Environmental Modifications

l. Vehicle Modifications
m. Adaptive and Assistive Technology
n. Non-Medical Transportation

3. Medicaid State Plan services
    a. Screening, preventive, diagnostic and treatment services related to physical health, including but not limited to:
        i. Ongoing treatment of chronic conditions as specified in treatment plans
        ii. Diagnosis and treatment related to episodic care for minor ailments, illness, or injuries, including sick visits
        iii. Primary pediatric/adolescent care
        iv. Immunizations in accordance with NYS or NYC recommended childhood immunization schedule
        v. Reproductive health care
        vi. Laboratory tests
    b. Screening, preventive, diagnostic, and treatment services related to developmental and behavioral health. This includes the following:
        i. Psychiatric consultation, assessment, and treatment
        ii. Psychotropic medication treatment
        iii. Developmental screening, testing, and treatment
        iv. Psychological screening, testing, and treatment
        v. Smoking/tobacco cessation treatment
        vi. Alcohol and/or drug screening and intervention
        vii. Laboratory tests

Other Limited Health-Related Services **do not** include the following services, which should be provided by Medicaid participating providers (i.e. essential community providers) and billed directly by these providers to MMCPs/Medicaid FFS:

- surgical services
- dental services
- orthodontic care
- general hospital services including emergency care
- birth center services
- emergency intervention for major trauma
- treatment of life-threatening or potentially disabling conditions

Other Limited Health-Related Services do not include nursing services, skill building activities (provided by LBHPs as described *Article 29-I VFCA Health Facilities License Guidelines* and any subsequent updates), and Medicaid treatment planning and discharge planning, including medical escorts and any clinical consultation/supervision services and tasks associated with the Managed Care Liaison/administrator in 29-I Health Facilities. These services are included in the Preventive or Rehabilitative Residential supports of the mandatory Core Limited Health-Related Services.

Other Limited Health-Related Services may be provided to children/youth in the care of any 29-I Health Facility, including children/youth in foster care, children/youth placed in a 29-I Health Facility by Committee on Special Education (CSE), babies residing with their parent who are placed in a 29-I Health Facility and in foster care, pre-dispositional placed youth, and children/youth in foster care placed in a setting certified by the Local Department of Social Services (LDSS).

Children/youth who are discharged from a 29-I Health Facility may continue to receive Other Limited Health-Related Services from any 29-I Health Facility up to one-year post discharge. These services may continue beyond the one-year post discharge date, if any of the following apply:

- child/youth is under 21 years old and in receipt of services through the 29-I Health Facility for an Episode of Care and has not yet safely transitioned to an appropriate provider for continued necessary services; or
- the child/youth is under 21 years old and has been in receipt of CFTSS or Children's HCBS through the 29-I Health Facility and has not yet safely transitioned to another designated provider for continued necessary CFTSS or HCBS in accordance with their plan of care; or
- if the Enrollee is 21 years or older, providers may bill for Other Limited Health-Related Services when the following applies:
  - the Enrollee has been placed in the care of the 29-I Health Facility and has been in receipt of Other Limited Health-Related Services prior to their 21st birthday, and the Enrollee has not yet safely transferred to another placement or living arrangement: and
  - the Enrollee and/or their authorized representative is compliant with a safe discharge plan; and
  - the 29-I Health Facility continues to work collaboratively with the MMCP to explore options for the Enrollee's safe discharge, including compliance with court ordered services, if applicable.

The Medicaid residual per diem is not reimbursable after the individual's 21st birthday. Adults over the age of 21 are not eligible for CFTSS or Children's HCBS.

For the purposes of this document, Episode of Care is defined as a course of treatment that began prior to discharge by the same facility to the child/youth for the treatment of the same or related health and/or behavioral health condition and may continue within one year after the date of the child/youth's discharge from the 29-I Health Facility. Additional details (i.e. service descriptions, staffing requirements, practitioner qualifications, required assessments) for Core Limited Health-Related Services and Other Limited Health-Related Services can be found in the Article 29-I VFCA Health Facilities License Guidelines.

3.5 CONCURRENT BILLING

In circumstances in which the child is receiving services from an Article 29-I Health Care Facility and a community provider such as an Article 31 or Article 28, there should be no duplication of services. When a clinical need is identified that is distinctly different and not duplicative to those needs being addressed through the 29-I Health Facility, it may be determined medically necessary for both services to be provided concurrently.

For example, there may be cases in which the Article 29-I therapist is providing individual therapy to the child and identifies the need for family therapy. If, based on the needs of the family/caregivers, the therapist determines it necessary and beneficial for the family therapy to be provided in an Article 31 clinic, this would be appropriate and allowable. In this case, both the Article 29-I therapist and Article 31 therapist would have separate treatment plans addressing different goals and objectives in therapy, thus substantiating distinct clinical needs and interventions for each service. In accordance with best practice, the Article 29-I therapist and Article 31 therapist are expected to collaborate, with consent from the child and family, to assure alignment in their treatment interventions.

3.6 OTHER LIMITED HEALTH-RELATED SERVICES FEE SCHEDULE

Other Limited Health-Related Services are reimbursed on a standardized fee schedule for services that the 29-I Health Facility provides (see Appendix C for a list of these services and codes).

The Other Limited Health-Related Services Fee Schedule can be found at

Foster Care Article 29-I Other Limited Health Services Schedule Summary (ny.gov).

29-I Health Facilities will be reimbursed for Core and Other Limited Health-Related Services by MMCPs for children enrolled in Medicaid Managed Care or by Fee-For-Service Medicaid for children who are not enrolled in Medicaid Managed Care.

3.7 AGENCIES WITHOUT A 29-I LICENSURE

Agencies that do not obtain Article 29-I Licensure are not authorized to receive a Medicaid per diem to provide Core Limited Health-Related Services and are not permitted to bill for Other Limited Health-Related Services.

3.8 CORE LIMITED HEALTH-RELATED SERVICES REGIONS

Core Limited Health-Related Services are not subject to regional reimbursement differences, as the Medicaid per diem was calculated as a statewide Medicaid rate. The Medicaid per diem is assigned to 29-I Health Facilities based on the facility types they are authorized to operate under an Article 29-I License.

3.9 OTHER LIMITED HEALTH-RELATED SERVICES REGIONS

The regions as defined by the Department of Health and assigned to providers based upon the geographic location of the provider's headquarters are defined as follows:

- Downstate: 5 boroughs of New York City, counties of Nassau, Suffolk, Westchester, Rockland, Putnam, Orange, Dutchess, Sullivan and Ulster
- Upstate: Rest of state

3.10 MEDICAID MANAGED CARE PLAN PAYMENTS

MMCPs must reimburse the NYS Medicaid FFS rates for Core Limited Health-Related Services for the four-year transition period from July 1, 2021 through June 30, 2025. MMCPs must reimburse Other Limited Health-Related Services for the four-year transition period at the Medicaid FFS fee schedule (where available), unless alternative arrangements have been made between Plans and providers and have been approved by DOH and OCFS (e.g., Value-Based Payment arrangements). MMCPs should submit passthrough payments for Core Limited Health Related Services to the State within 30 days of claim payment, and no later than 180 days from date of service. For pass through claims that are submitted more than 90 days after the date of service, Plans should use Delay Reason Code "03" to avoid claims rejecting due to untimely filing. Please note, while use of Delay Reason Code 03 typically requires claim submission on paper, the State has implemented a system edit to allow for Managed Care Plans to 29-I Core Limited Health Related Services claims electronically when using Delay Reason Code 03.

At the end of the transition period, the State will reassess progress of the implementation and determine if transitional requirements should be extended.

3.11 OTHER LIMITED HEALTH RELATED SERVICES DELIVERED WITH AN INTERPRETER

Reimbursement for Interpreter Services for children/youth receiving care by a 29-I Health Facility is available for services provided during a medically necessary encounter for the

following Other Limited Health-Related Service rate codes: **4588, 4589, 4590, 4591, 4592, 4593, 4594, 4595, 4596, 4597, 4598, 4685.**

The need for medical language interpreter services must be documented in the medical record and must be provided during an encounter. The 29-I Health Facility is responsible for developing a business relationship with one or more agencies that can provide trained, competent interpreters in the needed language(s). Interpreter services provided by 29-I Health Facility staff are not eligible for reimbursement. These interpreter services may be provided in person by an interpreter or by telephone with a translation service. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics, and terminology. It is recommended, but not required, that such individuals be recognized by the National Board of Certification for Medical Interpreters (NBCMI). The provider must document the encounter in the child/youth's medical record and include the location, type of interpretation provided, name of interpreter, and agency. Interpretation services also includes sign language for individuals who are deaf or hearing impaired.

Rate Code	Procedure code	Modifier	Max Units	Description
4673	T1013		2 units/encounter	In person interpreter services
4673	T1013	GQ	2 units/encounter	Telephone interpreter services

One Unit: Includes a minimum of eight and up to 22 minutes of medical language interpreter services.

Two Units: Includes 23 or more minutes of medical language interpreter services.

The time billed for interpretation services cannot exceed the length of time of the encounter. Claims must be submitted by the 29-I Health Facility providing the service. The rate of payment will be set at $11.00 for one unit of service up to a maximum of two billable units of service per patient per encounter. If the child/youth is seen for more than one encounter in a day, interpretation services may be billed for up to two units per encounter. Each claim must include **rate code 4673** and Healthcare Common Procedure Coding System (HCPCS) **procedure code T1013** (sign language and oral interpretation) in addition to the units of service. If provided via telephone the claim must include modifier **GQ.** The claim for language assistance shall only be

submitted subsequent to adjudication of the corresponding OLHRS (rate codes 4588-4598, and 4685) claim or it will deny.

3.12 PROVISION OF 29-I SERVICES BY INTERNS AND LIMITED PERMITTEES

State regulations regarding the designation of providers of children's behavioral health and health services 18 NYCRR 505.38 require licensure of professionals under Title VIII of the Education Law. Student interns and limited permittees practicing within the scope of the New York State Education Law can deliver 29-I Core and Other Limited Health-Related Services under the supervision of a licensed practitioner in the same field. Student interns without a license from the New York State Education Department Office of the Professions and limited permittees cannot enroll in Medicaid. Therefore, when submitting a claim for a service delivered appropriately by an intern or limited permittee, 29-I Health Facilities must either report the National Provider Identification (NPI) number of the supervising practitioner or the OCFS unlicensed provider code (05448682) in the Attending Practitioner field on the claim for these services until otherwise directed by the State. This does not allow for billing of services rendered by other unlicensed providers that are not explicitly authorized to deliver OLHRS in the 29-I Health Facility.

For more information: NYSED Office of the Professions
http://www.op.nysed.gov/opsearches.htm and contact
https://eservices.nysed.gov/professions/contact-us/#/

3.13 PROVISION OF 29-I SERVICES BY PREVIOUSLY EXEMPT UNLICENSED PROVIDERS

29-I Health Facilities are permitted to employ and bill for services provided by unlicensed individuals who were employed by a 29-I or other authorized setting as of June 24, 2022, who continue to work at the 29-I or in another authorized setting who meet the following criteria:

> 1) Students enrolled in a degree granting program leading to licensure of Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor (LMHC), Licensed Marriage and Family Therapist (LMFT), Licensed Psychotherapist (LP) or Licensed Creative Arts Therapist (LCAT), **OR**
>
> 2) Individuals who hold a baccalaureate of social work or higher, **OR**
>
> 3) Individuals who hold a master's degree or higher in a behavioral health profession.

Unlicensed professionals must be supervised by a licensed psychiatrist, physician, psychologist, master social worker, clinical social worker, mental health counselor, marriage and family therapist, psychoanalyst, licensed creative arts therapist, nurse practitioner, or registered professional nurse.

Facilities employing license-exempt individuals must follow all required employment verification and reporting requirements including completion of the Form to Document New York State Professional Licensure Exemption, as applicable.

SECTION 4: CLAIMS

4.1 REQUIREMENTS TO QUALIFY FOR MEDICAID REIMBURSEMENT

For services to qualify for Medicaid reimbursement, the child's/youth's health/behavioral health record, treatment plan, service plan and/or plan of care must reflect that the services provided:

- were medically necessary and appropriate (see Appendix A), and
- were rendered by qualified practitioners within their scope of practice (including supervision requirements), as defined in applicable State Law

Health/behavioral health care services must meet reasonable and acceptable standards of health practice as determined by the State in consultation with recognized health organizations. These standards include:

- State-mandated licensure requirements any other State-mandated certification and programmatic requirements that impact:
    - the types of providers that can deliver the services;
    - the specific nature of the services; and
    - the programmatic framework within which the services can be delivered, including supervision requirements.

Additionally, the services must be those that are covered by New York State Medicaid.

4.2 MEMBER ENROLLMENT STATUS

Before delivering services to an individual, providers should always check ePaces to verify the individual's Medicaid enrollment status and MMCP enrollment status. Providers should verify individual Medicaid and MMCP enrollment through the NYS system. Claims will not be paid if a claim is submitted for an individual who is not enrolled with Medicaid, an individual is not eligible for the service provided, or if the claim was submitted to an incorrect MMCP. Providers should always verify that claims are submitted to the correct MMCP.

Providers may appeal claims that have been denied; providers may contact the MMCP for information on how to appeal claim denials. In certain circumstances, providers may file a complaint or external appeal with State agencies. See also https://www.health.ny.gov/health_care/managed_care/complaints/.

4.3 29-I HEALTH FACILITY MEDICAID FEE-FOR-SERVICE CLAIMING (EMEDNY)

Claims for services delivered to an individual in receipt of fee-for-service Medicaid are submitted by providers to eMedNY. See https://www.emedny.org for training on use of the eMedNY system.

Claim submissions must adhere to the 90-day timely filing rules for Medicaid FFS. See State Medicaid billing guidance available at https://www.emedny.org/info/TimelyBillingInformation_index.aspx .

4.4 GENERAL MEDICAID MANAGED CARE CLAIMING FOR 29-I HEALTH FACILITIES (ALL SERVICES)

MMCPs and providers must adhere to the billing and coding manual requirements of this manual as well as clean claiming rules as outlined in billing tool found here: https://29ibilling.ctacny.org/

The MMCP shall support both paper and electronic submission of claims for all claim types. The MMCP shall offer providers an electronic payment option including a web-based claim submission system. MMCPs rely on Current Procedural Terminology (CPT) codes and modifiers when processing claims. Therefore, all MMCPs will require claims to be submitted with the CPT code and modifier (if applicable) in addition to the State-assigned rate code. Please refer to Appendix B and Appendix C for a complete listing of CPT codes and associated modifiers. Claims must include a National Provider Numbers (NPI) associated with the 29-I Health Facility.

MMCPs will be provided with a complete listing of all existing 29-I Health Facilities and the rate codes they are authorized to bill under, as well as the rate amounts by MMIS provider ID, locator code, and/or NPI and zip+4. Billing requirements depend on the type of service provided.

Providers must adhere to timely filing guidelines as outlined in their contract with the MMCP and per eMedNY guidelines (https://www.emedny.org/info/TimelyBillingInformation_index.aspx). When a clean claim is received by the MMCP, they must adjudicate per prompt pay regulations. If a provider does not have a contract or a Single Case Agreement in place with the MMCP, the claim can be denied. Providers may contact the MMCP for information on how to appeal claim denials. In certain circumstances, providers may file a complaint or external appeal with State agencies. See also https://www.health.ny.gov/health_care/managed_care/complaints/

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the member is eligible to receive. Medicaid is the payor of last resort and all Medicare and third-party coverage must be exhausted before payment for 29-I health services by Medicaid. However, 29-I health facilities are not required to bill and receive a denial from third party health insurance (TPHI) prior to billing for Core and OLHRS for children/youth

in foster care, including HCBS and CFTSS provided to foster care children/youth by a 29-I Health Facility.

For Medicaid members who are not in foster care, including children/youth who have been discharged from foster care and children/youth placed with the facility by the Committee on Special Education, acceptable documentation of attempts to secure third party reimbursement before billing Medicaid, as required under 18 NYCRR §540.6, must be maintained. Acceptable documentation includes documentation of a rejection by third party insurance for a date of service within the previous 12 months of the date of service being billed, or since a change in third party coverage, whichever is later. See the following regulation for more information: https://regs.health.ny.gov/content/section-5406-billing-medical-assistance.

4.5 MEDICAID MANAGED CARE CLAIMING FOR CORE LIMITED HEALTH-RELATED SERVICES

For 837i and UB-04 claims, the 29-I Health Facility will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in “24” followed immediately with the appropriate four-digit rate code. This is the standard mechanism used in Medicaid FFS billing.

The **837i** (electronic) or **UB-04** (paper form) is used to bill for Core Limited Health-Related Services. Every claim must include the following:

- Primary Diagnosis code using (https://www.cms.gov/medicare/coding-billing/icd-10-codes)
- Core Limited Health-Related Services rate codes (Appendix B)
- Valid CPT code(s)
- CPT code modifiers (as needed)
- Units of service
- Patient reason for visit code
- Revenue Codes (Appendix E)
- Bill Type (079*x) – please note that the last digit for the Bill Type represents the sequence of this claim in the episode of care to account for corrected and resubmitted claims*

General Billing Guidance for Institutional service claims (837i/UB-04) form can be found at https://www.emedny.org/ProviderManuals/AllProviders/General_Billing_Guidelines_Institutional.pdf

Guidance regarding billing for the use of interpretation services can be found at https://www.health.ny.gov/health_care/medicaid/program/update/2012/oct12mu.pdf

4.6 SUBMITTING CORE LIMITED HEALTH-RELATED SERVICES CLAIMS FOR DAILY BILLED SERVICES

Core Limited Health-Related Services are billed daily and can be submitted with a range of multiple dates of service on one claim. Claims for Core Limited Health-Related Services must be submitted to the MMCP that the member is enrolled in and must be submitted in accordance with the billing guidance provided by the Plan.

4.7 CORE LIMITED HEALTH-RELATED SERVICES CODING TABLE

Appendix B lists the rate codes, procedure codes, and modifier code combinations that will be required under Medicaid Managed Care to bill for the Medicaid residual per diem. Providers will use these coding combinations to indicate to the MMCP that the claim is for services provided to children/youth in the care of a 29-I Health Facility. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

4.8 OTHER LIMITED HEALTH-RELATED SERVICES MEDICAID MANAGED CARE PLAN CLAIMING

For 837i and UB-04 claims, the 29-I Health Facility will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in "24" followed immediately with the appropriate four-digit rate code. This is the standard mechanism used in Medicaid FFS billing.

The 837i (electronic) or UB-04 (paper form) is used to bill for Core Limited Health-Related Services and Other Limited Health-Related Services. Every claim must include the following:

- Primary Diagnosis code using (https://www.cms.gov/Medicare/Coding/ICD10)
- Other Limited Health-Related Services rate codes (Appendix C)
- Valid CPT code(s)
- CPT code modifiers (as needed)
- Units of service
- Patient reason for visit code
- Revenue Codes (Appendix E)
- Bill Type (079*x) – please note that the last digit for the Bill Type represents the sequence of this claim in the episode of care to account for corrected and resubmitted claims*

General Billing Guidance for Institutional service claims (837i/UB-04) form can be found at https://www.emedny.org/ProviderManuals/AllProviders/General_Billing_Guidelines_Institutional.pdf.

Guidance regarding billing for the use of interpretation services can be found at https://www.health.ny.gov/health_care/medicaid/program/update/2012/oct12mu.pdf.

Providers must include the applicable rate code, CPT codes, and modifiers (see Appendix C for billable and non-billable procedure codes). If there are two modifiers needed for one procedure code, both modifiers must be present and do not require a provider to indicate them in the exact same order for every claim for payment to be made.

4.9 SUBMITTING OTHER LIMITED HEALTH-RELATED SERVICES CLAIMS FOR DAILY BILLED SERVICES

Other Limited Health-Related Services are billed daily. When submitting an MMCP claim for Other Limited Health-Related Services delivered to the same child/youth on the same date and under the same rate code, **submit one claim for each rate code**. On each claim, report the procedure codes that reflect the services delivered during the encounter that are applicable to the rate code. If the procedure codes are billable, the units should reflect the length of the encounter related to each billable procedure code. Non-billable procedure codes submitted on MMCP claims will have one unit and will be reimbursed at $0. Non-billable procedure codes submitted on FFS claims will have zero units and will not be reimbursed. Although these codes are not associated with a fee they should be reported on the claim to accurately represent services delivered during the encounter. Each rate code should be billed on separate claim.

When an MMCP has a contract with a Behavioral Health Organization (BHO) to assist with review and processing of behavioral health claims, it may result in the need for providers to send behavioral health claims directly to the BHO and physical health claims to the MMCP. Providers must be aware of these agreements and be able to route claims to the appropriate place for timely reimbursement. The provider should speak directly to the MMCP they have contracted with for additional information.

4.10 OTHER LIMITED HEALTH-RELATED SERVICES CODING TABLE

Appendix C lists the common rate codes, CPT codes, and modifier code combinations that will be required to bill Medicaid Managed Care for the Other Limited Health-Related Services. Providers can add additional CPT codes, if appropriate, with the rate code descriptions outlined in this manual and consistent with CPT coding standards.

Laboratory services must be billed using the Laboratory Fee schedule found at Provider Manuals - Laboratory (emedny.org)

CFTSS and HCBS billing codes are located in the Children's Home and Community Based Services Manual and the Children and Family Treatment and Support Services Manual.

4.11 CLAIMS TESTING

To facilitate a smooth transition to Medicaid Managed Care billing, the MMCPs will offer billing/claim submission training to newly contracted providers and providers in active contract

negotiations. This will include testing claims submission and processing, and issuance of MMCP contact and support information to assist programs in claim submission.

Providers are expected to test the claims submission process with MMCPs for all delivered services prior to the service implementation date and upon executing a new contract. Claims testing should begin 90 days prior to the implementation date.

4.12 ABSENCES AND IMPACT ON CLAIMING

The Medicaid residual per diem rate may not be claimed by the 29-I Health Facility when a foster care youth is temporarily absent from the 29-I Health Facility under any circumstances other than those specified in this Manual and future Department updates.

Absence Categories when it is Permissible to Claim the Medicaid Residual Per Diem:
It is permissible to claim the Medicaid residual per diem rate for **consecutive days one through seven, per episode of absence** for the following absence categories:

- Trial discharge
    - The 29-I Health Facility may claim their Medicaid rate for the first consecutive seven days of the trial discharge period per episode of trial discharge. An episode of trial discharge ends when the child/youth is either returned to the physical custody of the 29-I Health Facility or finally discharged from the 29-I Health Facility, preparatory to final foster care discharge.
- Non-secure legal detention
- Absent without consent (AWOC)
    - The 29-I Health Facility may claim the Medicaid residual per diem rate for the first consecutive seven days of AWOC, per AWOC episode, under the condition that the responsible authorized agency uses diligent efforts to locate and return the youth to the 29-I Health Facility and follows all other requirements of NYS OCFS regulation 18 NYCRR 431.8 and any NYS OCFS regulation and policy updates related to AWOC.

It is permissible to claim the 29-I Health Facility Medicaid residual per diem rate for **all days** of the following absence categories:

- Weekday and weekend visits, up to seven consecutive days per visit
- School and religious holidays
- Vacation days (including stay at camp)
    - All vacation days up to 21 days per calendar year, the maximum number that NYS OCFS specifies
- Visits to potential foster or adoptive parents, up to seven consecutive days per visit the maximum that NYS OCFS specifies
- Organized school trips

- Respite care and services (non-institutional and institutional)

Specifically, respite care may be reimbursed up to a maximum of seven weeks in any calendar year, not to exceed 21 consecutive days per episode, with a period of at least seven consecutive days before a subsequent respite care episode may be reimbursed.

Absence Categories when it is Not Permissible to Claim the Medicaid Residual Per Diem:

In the following circumstances of absence, it is not permissible to claim the 29-I Core Limited Health-Related Services (Medicaid residual per diem) rate:

- Inpatient hospital days
- Other residential facility/setting days when that entity is reimbursed via a Medicaid payment methodology that covers health care costs (i.e., skilled nursing facility, residential school, or psychiatric center)
- Day of transfer or discharge from the 29-I Health Facility
    - The Medicaid rate may be claimed for the day of admission to a 29-I Health Facility.
    - If a child/youth is transferred from one 29-I Health Facility to another 29-I Health Facility, the 29-I Health Facility making the transfer will receive payment for the day of transfer. The 29-I Health Facility receiving the child/youth will receive payment for the first full day that the child/youth is in their care.
    - 29-I Health Facility will receive payment for the day of discharge.
- Secure legal detention
- Out-of-state congregate care placement setting
- Home on trial discharge days after the seventh consecutive day of trial discharge, irrespective of how long the period of trial discharge lasts
- Non-secure legal detention days after the seventh consecutive day of non-secure legal detention, irrespective of how long the period of non-secure legal detention lasts, unless the setting for non-secure legal detention is either:
    - A different 29-I Health Facility than the one from which the youth is temporarily absent; or
    - Another residential facility that gets reimbursed via a Medicaid payment methodology or a non-Medicaid payment methodology that covers health care costs.

If the 29-I Health Facility has advised the fiscally responsible local department of social services (LDSS) that they will not accept the return of the absent youth in foster care to their agency, then:

- None of the absent days are reimbursable for the purposes of the Core Limited Health-Related Services (Medicaid residual per diem) rate; and

- The 29-I Health Facility must discharge the youth from their agency for purposes of payment of the childcare agency Medicaid rate; and
- Following the most current NYS OCFS regulatory requirements, the LDSS must initiate an appropriate placement following the absence (i.e., placement at a different 29-I Health Facility, a direct care foster care placement, etc.); and
- When the youth is discharged from foster care, the LDSS must follow the most current Medicaid eligibility redetermination requirements to facilitate seamless health care and health care coverage in the new placement setting.

29-I Health Facilities must comply with all NYS OCFS regulations and policies related to allowable absences. 29-I Health Facilities must keep abreast of all applicable NYS OCFS regulations and policies, and any updates related to temporary absences.

Special Categories of Absence and Impact on Claiming

The Core Limited Health-Related Services (Medicaid residual per diem) rate may be claimed by a 29-I Health Facility when a youth in foster care under their auspices attends an in-state or out-of-state college or university, or in a vocational/technical training setting.

For the purposes of the Core Limited Health-Related Services (Medicaid residual per diem) rate, these youth are "residents" of the 29-I Health Facility. The Core Limited Health-Related Services (Medicaid residual per diem) rate for these youth may be claimed until they reach 21 years of age.

4.13 OTHER LIMITED HEALTH-RELATED SERVICES BILLABLE UNITS

In addition to the Core Limited Health-Related Services (Medicaid residual per diem), 29-I Health Facilities may bill for encounter-based Other Limited Health-Related Services that are provided to meet a child/youth's individualized needs and are included in the facility's 29-I License. Appendix C includes rate codes, descriptions, units of service (i.e. 15 minutes, per dose, per occurrence), and unit limits per rate code for Other Limited Health-Related Services. All unit limits are "soft limits" and can be exceeded with medical necessity. If a service or procedure code requires time beyond the 15-minute unit in the fee schedule, the 29-I Health Facility may add additional 15-minute units to the claim in accordance with *Table 2: Timed units per Encounter of Service* in this manual, up to the maximum.

When determining the number of units to bill, use the appropriate procedure code as described in the American Medical Association CPT billing and coding manual.

Table 2: Timed Units per Encounter of Service

Range of minutes per face-to-face encounter	Billable minutes	Billable units (15 minutes per unit)
Under 8 minutes	1-7 minutes	Not billable
8-22 minutes	15 minutes	1 unit
23-37 minutes	30 minutes	2 units
38-52 minutes	45 minutes	3 units
53-67 minutes	60 minutes	4 units
68-82 minutes	75 minutes	5 units
83-97 minutes	90 minutes	6 units
98-112 minutes	105 minutes	7 units
113-127 minutes	120 minutes	8 units

In addition to rate codes, procedure codes are required when submitting Medicaid Managed Care claims. If an encounter requires multiple procedure codes to detail the services that were delivered, include all procedure codes that apply (including non-billable procedure codes).

Total time on the date of the encounter (office or other outpatient services [99202,99203,99204, 99205, 99212, 99213, 99214, 99215]): For coding purposes, time for these services is the total time on the date of encounter. It includes both the face-to face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by other clinical staff).

Time spent performing the following activities are billable when performed by a Physician or other qualified health care professional:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/ or evaluation
- Counseling and educating the patient /family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record

- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

4.14 PHYSICIAN ADMINISTERED DRUGS

The Medicaid Program reimburses drugs by dose at acquisition cost when administered by practitioners to their patients. Practitioners are required to maintain records that include drug invoice with dose(s) administered, for auditing purposes.

To facilitate electronic claim submission and timely payment to practitioners, the Medicaid Program consults national pricing references to establish a maximum reimbursable amount (MRA) on its procedure code reference file. Claims submitted for most practitioner-administered drugs will be paid at acquisition cost or up to the MRA. 29-I Health Facilities that provide practitioner administered drugs during an office visit must be enrolled in Category of Service 0163, to be reimbursed. Electronic claims must be submitted on an 837i claim form. Note, drugs listed on the Physician Fee Schedule with a notation of BR (By Report) under column E "BR," must be submitted on a paper HCFA 1500 Claim Form, with a copy of the itemized invoice as documentation. Regardless of claim type or whether a particular drug is designated as BR in the Medicaid Physician Fee Schedule, practitioners must limit their charge amount to their acquisition cost as established by invoice for the dose administered. The NYS Medicaid Physician Drug and Drug Administration Services Fee Schedule can be found here: https://www.emedny.org/ProviderManuals/Physician/index.aspx

Additional information on FFS billing can be found here: https://www.health.ny.gov/health_care/medicaid/program/practitioner_administered/ffs_practitioner_administer.htm

Information related to drugs that are not administered by a practitioner can be found with pharmacy program information in Section 4.17.

29-I Health Facilities are encouraged to reach out to the MMCPs that serve children/youth in their care to better understand the MMCP's process and requirements for reimbursement of physician administered drugs.

4.15 COST ALLOCATION OF SERVICES

Other Limited Health-Related Services must be provided and billed for separately from those services included in the Core Limited Health-Related Services. 29-I Health Facilities may not separately bill for activities performed by a professional when the Full Time Equivalent (FTE) for that position is funded within the Medicaid residual per diem rate for the provision of Core Limited Health-Related Services.

29-I Health Facilities must appropriately allocate the costs associated with each type of service in the annual cost report filings submitted to the State. Costs associated with the time spent by practitioners providing Core Limited Health-Related Services must be allocated to and billed under the Medicaid residual per diem. 29-I Health Facilities can allocate percentages of individual practitioners' FTEs to Core and Other Limited Health-Related Services, based on actual time spent providing those services. 29-I Health Facilities may not bill for services provided by an individual practitioner under both the Medicaid residual per diem and the Other Limited Health-Related Services fee schedule, without an appropriate cost allocation methodology in place.

Providers must also comply with the HCBS Settings Rules as outlined in Appendix F.

4.16 BILLING EXAMPLE: OFFICE VISIT

When billing for an office visit, the claim would include rate code 4594, one of the billable E&M or prevention procedure codes (99202-99205, 99212-99215, 99381-99385, 99391-99395, 99401-99404), and any additional non-billable procedure codes relevant to the services that was provided; see Appendix C for additional non-billable codes. For example, if a child/youth was a new patient with moderate presenting problems (based on medical decisions of the practitioner seeing the child/youth for the visit) and the child/youth was seen for 45 minutes, the claim must reflect the following information:

Rate code	Procedure Code description	Modifier	Procedure Code	Billable Units	Units Billed
Unit Limit 12 units/day					
4594	New Patient Office or outpatient visit (typically 30 minutes) usually presenting problem(s) are moderate severity	U9, SC	99204 (billable code)	15 minutes	3 units
	Service(s) provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g. holidays, Saturday, or Sunday) in addition to basic service	N/A	99050 (non-billable code)	N/A	0 (FFS)/ 1 (MMCP)
	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	N/A	90863 (non-billable code)	N/A	N/A 0 (FFS)/ 1 (MMCP)

If there are multiple billable services delivered under the same rate code during one encounter, each billable service must be indicated on the same claim with distinct procedure, modifier, and units delivered. Each rate code must be reported on a separate claim.

4.17 SUBMITTING AN OTHER LIMITED HEALTH RELATED SERVICE FFS CLAIM

When submitting FFS Other Limited Health-Related Service claims for services delivered to the same child/youth, during the same day and under the same rate code, 29-I Health Facilities will need to **submit one claim indicating one rate code**. On each claim, report the procedure codes that reflect the services delivered during the encounter that are applicable to the rate code. If the procedure codes are billable, the units should reflect the length of the encounter related to each billable procedure code. Non-billable procedure codes on FFS claims will have zero units and will not be reimbursed; however, they should be reported on the claim to accurately represent the services delivered during the encounter. Each rate code should be billed on a separate claim.

FFS Example: If a 29-I Health Facility provides Developmental Test Administration using rate code 4589 for one hour and thirty minutes, the claim would need to reflect rate code 4589, procedure codes 96112 and 96113 with a total of 6 units on the claim. **All units being claimed for the rate code for FFS claim must be reported on the first line to pay. See Table 3, below:**

Table 3: FFS Claims Example			
Example: (Same date of service) 9/2/2021	Same Child: “Youth receiving care”	**Procedure code**	**Units**
Rate Code 4589 **(same rate code)**		96112	6
		96113	0

4.18 SUBMITTING AN OTHER LIMITED HEALTH-RELATED SERVICE MMCP CLAIM

When submitting MMCP **Other Limited Health Related-Service claims** for services delivered to the same child/youth, during the same day and under the same rate code, submit one claim indicating one rate code. On each claim, report the procedure codes that reflect the services delivered during the encounter related to the rate code. Non-billable procedure codes will have one unit and will be paid at $0; however, they should be reported on the claim to accurately represent services delivered during an encounter. Each rate code should be billed on a separate claim.

MMCP Example: If a 29-I Health Facility provides Developmental Test Administration using rate code 4589 for one hour and thirty minutes, the claim would need to reflect rate code 4589, procedure codes 96112 and 96113 with a total of 6 units on the claim**. If more than one procedure code is billable on the claim the units must reflect what was delivered in the encounter. Non-billable procedure codes will be indicated as one unit on the managed care**

claim and will pay at $0. Only the billable portion of the claim will be associated with a payment amount. See Table 4, below:

Table 4: Managed Care Claims Example			
Example: (Same date of service) 9/2/2021	Same Child: “Youth receiving care”	**Procedure code**	**Units**
Rate Code 4589 (same rate code)		96112	4
		96113	2

4.19 DESCRIPTION OF BILLABLE PROCEDURE CODES FOR OTHER LIMITED HEALTH-RELATED SERVICES

A description of billable procedure codes for Other Limited Health-Related Services is as follows:

Alcohol and /or drug screening, testing and treatment: rate code 4588

- **Procedure code H0049:** Alcohol and/or drug screening
- **Procedure code H0050:** Alcohol and/or drug service, brief intervention, per 15 min
- **Procedure code 99408:** Alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT DAST) and brief intervention (SBI) services 15 to 30 minutes
- **Procedure code 99409:** Alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT DAST) and brief intervention (SBI) services greater than 30 minutes

When using the CRAFFT tool for alcohol and/or drug screening use one of the above procedure codes.

Developmental test administration: rate code 4589

- **Procedure Code 96112:** Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report**; first hour**
- **Procedure code 96113:** Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/or executive functions by standardized developmental instruments when performed), by physician or

other qualified health care professional, with interpretation and report; **additional 30 minutes**

Psychotherapy (Individual and Family): rate code 4590

- **Procedure code 90832:** Psychotherapy, 30 min with child/youth
- **Procedure code 90834:** Psychotherapy, 45 min with child/youth
- **Procedure code 90837:** Psychotherapy, 60 min with child/youth
- **Procedure code 90846:** Family Psychotherapy (without the child/youth) 50 minutes. Sessions that are less than 26 minutes without the child/youth present are not eligible for reimbursement.
- **Procedure code 90847:** Family Psychotherapy (conjoint psychotherapy with child/youth present) 50 minutes. Sessions where the child/youth is present may be billed by a 29-I Health Facility if they are at least 8 minutes.

Psychotherapy (Group): rate code 4591

- **Procedure code 90849:** Family Psychotherapy Multi-Family Group Psychotherapy
- **Procedure code 90853:** Group Psychotherapy (other than of a Multi-family)

Neuropsychological testing evaluation services: rate code 4592

- **Procedure code 96132:** Neuropsychological testing evaluation services by physician or other qualified health care professional, standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, **first hour**
- **Procedure code 96133**: Neuropsychological testing evaluation services by physician or other qualified health care professional, standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, **each additional hour (list separately on same claim) in addition to code for primary procedure**

Psychiatric/Psychological diagnostic examination: rate code 4593

- **Procedure code 90791:** Can be billed once per day and not with an evaluation management claim (Office visit rate code 4594, Procedure codes 99213, 99214, and 99215) claim on the same day, can be billed twice per day when patient is evaluated and then patient with other informant or other informants without patient
- **Procedure code 90792:** Can be billed once per day and not with an evaluation management claim (Office visit rate code 4594, Procedure codes 99213, 99214, and 99215) on the same day, can be billed twice per day when patient is evaluated and then patient with other informant or other informants without patient, includes medical services
- **Procedure code 96136:** Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes

- **Procedure code 96137:** Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, each additional 30 minutes (List separately in addition to code for primary procedure on same claim)
- **Procedure code 96130:** Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
- **Procedure code 96131:** Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; Each additional hour (List separately in addition to code for primary procedure on same claim)

Medical Nutrition Therapy: Rate Code 4685

- **Procedure Code 97802:** Initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
- **Procedure Code 97803:** Medical Nutrition Therapy follow up, re-assessment, and intervention, individual, face-to-face with the patient, each 15 minutes

Office Visit: rate code 4594

- **Procedure code 98016:** Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 8-10 minutes of medical discussion. Do not report 98016 in conjunction with 98000-98015. Do not report services of less than 8 minutes of medical discussion. This is a patient-initiated service.
- **Procedure code 99202:** New Patient Office or outpatient visit (typically 20 minutes) usually presenting problem(s) are moderate severity
- **Procedure code 99203:** New Patient Office or outpatient visit (typically 30 minutes) usually presenting problem(s) are moderate to high severity
- **Procedure code 99204:** New Patient Office or outpatient visit (typically 45 minutes) usually presenting problem(s) are moderate to high severity
- **Procedure Code 99205:** New Patient Office or outpatient visit (typically 60 minutes) usually presenting problem(s) are moderate to high severity
- **Procedure code 99212:** Established Patient Office visit (typically 10 minutes) usually the presenting problem(s) are self-limiting or minor

- **Procedure code 99213:** Established Patient Office visit (typically 15 minutes) usually the presenting problem(s) are low to moderate severity
- **Procedure code 99214:** Established Patient Office visit (typically 25 minutes) usually presenting problem(s) are moderate to high severity
  Procedure code 99215, Established Patient Office visit (typically 40 minutes) usually presenting problem(s) are moderate to high severity
- **Procedure code 99381:** Preventive Medicine – Initial comprehensive evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; **infant (younger than 1 year)**
- **Procedure code 99382:** Preventive Medicine – Initial comprehensive evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood **(age 1 through 4 years)**
- **Procedure code 99383:** Preventive Medicine – Initial comprehensive evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient**; late childhood (age 5 through 11 years)**
- **Procedure code 99384:** Preventive Medicine – Initial comprehensive evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; **adolescent (age 12 through 17 years) Procedure code 99385:** Preventive Medicine – Initial comprehensive evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; **18 – 39 years**
- **Procedure code 99391:** Established patient periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; **infant (age younger than 1 year)**
- **Procedure code 99392:** Established patient periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; **early childhood (age 1 through 4 years)**
- **Procedure code 99393:** Established patient periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor

reduction interventions, and the ordering of laboratory/diagnostic procedures; **late childhood (age 5 through 11 years)** **Procedure code 99394:** Established patient periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; **adolescent (age 12 through 17 years)**

- **Procedure code 99395:** Established patient periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; **18-39 years**
- **Procedure code 99401:** Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual **approximately 15 minutes**
- **Procedure code 99402:** Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual **approximately 30 minutes**
- **Procedure code 99403:** Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual **approximately 45 minutes**
- **Procedure code 99404:** Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual **approximately 60 minutes**
- **Procedure code 99417** Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient **Evaluation and Management** services, It may not be used with any other office/outpatient code.) Do not report 99417 in conjunction with 99354, 99355, 99358, 99359, 99415, 99416. Do not report 99417 for any time unit less than 15 minutes. 99417 cannot be reported on the same day as non-face-to-face prolonged care codes 99358, 99359 or face-to-face prolonged care codes 99354, 99355. The entire 15 minutes must be done, in order to add on this new, prolonged services code to 99215 and 99205.

Use one of the billable procedure codes listed above for reproductive health related office visits.

When billing for an office visit, indicate what billable service was performed and any additional non-billable procedure codes (if applicable) to the Office Visit claim. Additional procedure codes will provide detail on how complex the visit was and what services were delivered. When coding the claim, ensure the most accurate coding using appropriate procedure codes based on established definitions defined in American Medical Association CPT coding manual.

Additional Non-Billable Procedure codes to be claimed with Office Visit rate code and procedure codes in Appendix C

- **Procedure code 11730:** Avulsion of nail plate, partial or complete, simple; single
- **Procedure code 11982:** Removal, non-biodegradable drug delivery system
- **Procedure code 11983:** Removal with reinsertion, non-biodegradable drug delivery implant
- **Procedure code 27372:** Removal of foreign body, deep, thigh region or knee area
- **Procedure code 58300:** Insertion of Intrauterine device (IUD)
- **Procedure code 58301:** Removal of Intrauterine device (IUD)
- **Procedure code 69200**: Removal foreign body from external auditory canal; without general anesthesia
- **Procedure code 94640**: Pressurized or non-pressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device
- **Procedure code 96372**: Therapeutic, prophylactic, or diagnostic injection subcutaneous or intramuscular
- **Procedure code 99050:** Service(s) provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g. holidays, Saturday, or Sunday) in addition to basic service
- **Procedure code 97804:** Medical Nutrition Therapy Group (2 or more individuals)
- **Procedure code S0630:** Removal of sutures by physician who did not close the wound
- **Procedure code S8110:** Peak Expiratory Flow Rate
- **Procedure code 90863:** Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services
- **Procedure code G2023:** COVID-19 Specimen Collection without onsite laboratory testing. Effective May 12, 2023, this code is no longer permissible for use in a 29-I setting.

Smoking cessation treatment: rate code 4595

- **Procedure code 99407:** (greater than 10 minutes)

ECG: rate code 4596

- **Procedure code 93000:** Rhythm ECG, 12 leads with interpretation report triggered by an event to diagnose – with specific order and documentation in medical record

Screening-development/emotional/behavioral: rate code 4597

- **Procedure code 96110:** Developmental screening (e.g. developmental milestone survey, speech, and language delay screen), with scoring and documentation, per standardized instrument
- **Procedure code 96160:** Administration of patient focused health risk assessment instrument (e.g. health hazard appraisal) with scoring and documentation, per standardized instrument

- **Procedure code 96161:** Administration of caregiver-focused health risk assessment instrument (e.g. depression inventory) for the benefit of the patient, with scoring and documentation per standardized instrument
- **Procedure code 96127:** Brief emotional/behavioral assessment (e.g. Depression inventory, attention deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

Hearing and evaluation of speech: rate code 4598

- **Procedure code 92551:** Screening pure test tone air only
- **Procedure code 92521:** Sound production (e.g. stuttering, cluttering)
- **Procedure code 92522:** Sound production (e.g. Articulation, phonological process, apraxia, dysarthria)
- **Procedure code 92523:** With evaluation of language comprehension and expression (e.g. Receptive and expressive language)
- **Procedure code 92524:** Behavioral and Qualitative analysis of voice and resonance
- **Procedure code 92526:** Treatment of swallowing dysfunction and/or oral function for feeding

Immunization Administration: rate code 4599

Vaccines for Children (VFC) Program

In New York, health care providers cannot bill Medicaid for vaccines they give to children/youth, as vaccines must be received through the Vaccines for Children (VFC) Program. The provider can bill separately for administration of the vaccine and must be enrolled in the VFC program to do so. A child is eligible for VFC vaccine if they are younger than 19 years of age and meets at least one of the VFC criteria.

Please reference https://www.health.ny.gov/prevention/immunization/vaccines_for_children/ for further information on New York's VFC program. Additional guidance regarding billing for this program is located at New York State Medicaid Update - July 2020 Volume 36 - Number 12 (ny.gov).

To be reimbursed for the administration of vaccines supplied by or available through the VFC Program, providers will be required to bill using the procedure code of the vaccine/toxoid administered, along with the "SL" modifier for ages 0 – 18 and "FB" modifier for ages 19+ (indicating the administration of a vaccine supplied by or available through the VFC Program or a vaccine supplied at no cost), and the vaccine administration CPT code. Please note that the "SL" modifier should be attached to the procedure code for the vaccine/toxoid administered and not to the administration code.

- **Procedure code 90460:** Administration of FREE vaccine
- **Procedure code 90471:** Administration of vaccine for youth 19 years of age and older
- **Procedure codes for the vaccine/toxoid administered:** Please reference pages 39 – 42 of The New York State Medicaid Program Physician – Procedure Codes Manual, located

at
https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_Procedure_Codes_Sect2.pdf

When administering multiple immunizations in one visit, indicate multiple administrations by increasing the number of billable units on the claim. For example, for three immunizations delivered to a child/youth in one visit, indicate 3 units to claim the three doses administered.

COVID-19 Vaccine Administration:
29-I Health Facilities may bill Medicaid FFS and MMC plans for administration of authorized COVID-19 vaccine when administered by provider or facility staff to Medicaid members in a residential or other institutional setting. The administration fee is in addition to the rate (i.e. per diem, per visit, per hour) reimbursed to the provider and must be billed to Medicaid separately. Rate-based providers may also bill for COVID-19 vaccine administration on a stand-alone claim when other services are not provided.

For a list of rate codes, procedure codes, rates, and further COVID-19 guidance, including guidance related to COVID vaccine counseling, please refer to https://health.ny.gov/health_care/medicaid/covid19/guidance/billing_guidance.htm for further information on New York State Medicaid Coverage Policy and Billing Guidance for the Administration of COVID-19 Vaccines Authorized for Emergency Use.

Laboratory Services:

Rate code 4600
- **Procedure code 80178**: Lithium

Rate code 4671
- **Procedure code 81002**: Urinalysis, by dip stick or tablet reagent; non-automated, without microscopy
- **Procedure code 81003**: Urinalysis, by dip stick or tablet reagent; automated, without microscopy
- **Procedure code 81007**: Urinalysis; Bacterium screen, except B

Rate code 4672
- **Procedure code 87426**: Infectious agent antigen detection by immunoassay technique (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19])

Rate code 4673

- **Procedure code T1013:** interpreter services (in person and telephone)

Rate Code 4674

- **Procedure code 81025**: Urine pregnancy test, by visual color comparison methods

Rate code 4675

- **Procedure code 83036**: Hemoglobin; glycosylated (A1C)

Rate code 4676

- **Procedure code 85018**: Blood count; Hemoglobin (HGB)

Rate code 4677

- **Procedure code 86701**: Antibody; HIV-1

Rate code 4678

- **Procedure code 87210**: Smear, primary source with Interpretation

Rate code 4679

- **Procedure code 87631**: Infectious agent detection by nucleic ac

Rate code 4680

- **Procedure code 87880**: Infectious agent detection by immunoassay

Rate code 4681

- **Procedure code 87804**: Infectious agent antigen detection by IM (Influenza rapid test)

Rate code 4682

- **Procedure code 87635:** Molecular PCR Test
- **Procedure code U0002:** Molecular PCR Test

Rate code 4683

- **Procedure code G2023:** COVID-19 Specimen Collection (can be reimbursed if specimen collection is a standalone service not associated with an office visit or a COVID-19 Molecular PCR test). Effective May 12, 2023, this code is no longer permissible for use in a 29-I setting and is no longer eligible for reimbursement.

Rate code 4684

- **Procedure code 86580:** All intradermal Tuberculosis (TB) tests, including TB skin tests, TB delayed hypersensitivity tests (DHT or DHR), Mantoux and/or tine tests and the purified protein derivative test (PPD)

29-I Health Facility Laboratory Fee Schedule		
Procedure Code	**Description**	**29-I Health Facility Fee**
	Drug Testing	
80178	Lithium	$8.00
	Urine Dip	
81002	Urinalysis, by dip stick or tablet reagent; non-automated, without microscopy	$2.00
81003	Urinalysis, by dip stick or tablet reagent; automated, without microscopy	$2.00
81007	Urinalysis; Bacterium scree, except B	$2.00
	Pregnancy Test	
81025	Urine pregnancy test, by visual color co	$2.00
	Hematocrit or Hemoglobin	
83036	Hemoglobin; glycosylated (A1C)	$11.00
85018	Blood count; Hemoglobin (HGB)	$2.00
	HIV	
86701	Antibody; HIV-1	$11.00
	Saline Prep	
87210	Smear, primary source with Interpretation	$4.00
	RSV	
87631	agent Infectious detection by nucleic ac	$97.00
	Strep Rapid	
87880	Infectious agent detection by immunoassay	$4.00
	Influenza Rapid Test	
87804	Infectious agent antigen detection by IM (Influenza rapid test)	$15.00
	COVID-19 Tests	
87635	Molecular PCR test (effective 3/13/2020) – INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19]), AMPLIFIED PROBE TECHNIQUE	$51.31
U0002	Molecular PCR test (effective 3/13/2020) – 2019-NCOV CORONAVIRUS, SARS-COV-2/2019-NCOV (COVID-19), ANY TECHNIQUE, MULTIPLE TYPES OR SUBTYPES (INCLUDES ALL TARGETS), NON-CDC.	$51.31

29-I Health Facility Laboratory Fee Schedule		
Procedure Code	**Description**	**29-I Health Facility Fee**
87426	Infectious agent antigen detection by immunoassay technique (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19])	$45.23
87637	Multiplex test: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types a and b, and respiratory syncytial virus, multiplex amplified probe technique.	$45.68
COVID-19 Specimen Collection		
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]) when provided as a stand-alone service. Effective May 12, 2023, this code is no longer permissible for use in a 29-I setting and is no longer eligible for reimbursement.	$23.46
All intradermal Tuberculosis (TB) tests		
86580	All intradermal Tuberculosis (TB) tests, including TB skin tests, TB delayed hypersensitivity tests (DHT or DHR), Mantoux and/or tine tests and the purified protein derivative test (PPD)	$5.00

Procedure code G2023 was reimbursable only when the specimen collection was a stand-alone service and was not reimbursable in conjunction with any other service, including an office visit or when billing for a COVID-19 test. Effective May 12, 2023, this code is no longer permissible for use in a 29-I setting and is no longer eligible for reimbursement.

29-I VFCA Health Facilities may only bill for one instance of each laboratory procedure per day. The performance of multiple laboratory procedures of the same type for the same child/youth on the same day is not reimbursable. However, the performance of multiple laboratory procedures of different types for the same child/youth on the same day remains reimbursable. For example, billing for both a Hemoglobin test and a COVID-19 polymerase chain reaction (PCR) test given to the same child/youth on the same day is permissible. If two PCR tests are given to the same child/youth on the same day; only one is reimbursable.

29-I Health Facilities providing laboratory services must have a valid Clinical Laboratory Improvement Amendments (CLIA) certification and only provide laboratory services outlined in their CLIA certification. The objective of the CLIA program is to ensure quality laboratory testing. All clinical laboratories must be properly certified to receive Medicaid reimbursement;

CLIA has no direct Medicare or Medicaid program responsibilities. Reimbursements will only apply to the specific waivered labs outlined in this manual. 29-I Health Facilities must provide proof of CLIA certification to the State upon request. Additional information on CLIA certifications can be found here: https://www.cms.gov/medicare/quality/clinical-laboratory-improvement-amendments. COVID testing must meeting the complexity of the laboratory certification. Additional information regarding CLIA-waived COVID tests can be found at https://www.fda.gov/medical-devices/covid-19-emergency-use-authorizations-medical-devices/in-vitro-diagnostics-euas#individual-molecular .

4.17 PHARMACY/DURABLE MEDICAL EQUIPMENT (DME)/SUPPLIES

Beginning April 1, 2023, Medicaid members enrolled in a MMCP, including children/youth placed in foster care, Health and Recovery Plans (HARPs), and HIV-Special Needs Plans (SNPs) will have their pharmacy benefits transitioned to NYRx, the Medicaid Pharmacy program formerly known as the Medicaid fee-for-service pharmacy program. The transition will not apply to members enrolled in Child Health Plus (CHPlus).

Most drugs currently covered by the MC plans will continue to be covered by NYRx; however, some drugs may require prior authorization.

The NYRx Pharmacy Benefit includes:

- Covered outpatient prescription and over the counter (OTC) drugs that are listed on the eMedNY "Medicaid Pharmacy List of Reimbursable Drugs" located at: https://www.emedny.org/info/formfile.aspx
    - More information on NYRx Pharmacy benefits, including the NYRx Formulary and a link to the Preferred Drug Program can be found at: https://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm
- Pharmacist administered vaccines and supplies, such as enteral and parenteral nutrition, family planning, and medical/surgical supplies, listed in *the New York State Medicaid Program Pharmacy Procedure Codes* document found at: https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Procedure_Codes.pdf
- Services related to COVID-19, including testing, with pharmacy-specific guidance found at: https://health.ny.gov/health_care/medicaid/covid19/guidance/index.htm

Additional Information and Questions:

- Providers must be enrolled in NYS Medicaid to provide services to Medicaid members. For information regarding provider enrollment, visit: https://www.emedny.org/info/ProviderEnrollment/HowDoIDo.pdf.
- Additional questions should be directed to providerenrollment@health.ny.gov or by calling Provider Enrollment at (800) 343-9000.

- For more information regarding the pharmacy benefit transition from NYS Managed Care to NYRx, visit: https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_transition.
- Additional guidance for which benefits are subject to the transition can be found in the Scope of Benefits chart found at: https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_transition/repository/rx_scope_of_benefits.htm
- Policy questions can be directed to the Medicaid Pharmacy Policy unit at (518) 486-3209 or by emailing nyrx@health.ny.gov
- Policy questions for DMEPOS providers can be directed to the Bureau of Medical Review at (800) 342-3005 or by emailing OHIPMEDPA@health.ny.gov.

4.18 ROUTINE TRANSPORTATION

Transportation related to accessing routine health care services is covered within the Core Limited Health-Related Services (Medicaid residual per diem) rate. It is the responsibility of the 29-I Health Facility to arrange for ordinary and routine health care-related transportation services required to serve the child/youth in their care, such as a trip to a local medical appointment.

4.19 MEDICAL TRANSPORTATION

29-I Health Facilities are not responsible for non-routine transportation. Examples include:

- Frequency of medical appointments exceeds regular and routine medical care
- Emergency ambulance transports
- Transportation between medical facilities
- Medical destinations which are long distance (i.e. 30 miles or more away from the facility
- Outside the common medical marketing area where ordinary and routine health care is received

These types of trips are arranged through the regional Department of Health contracted Medicaid Transportation Manager and are billed by the transportation provider as fee for service Medicaid transportation.

Medicaid enrollees have freedom of choice when choosing a transportation provider within the most cost effective, medically appropriate mode of transport (e.g. taxi/livery, ambulette, public transit) as determined by the Transportation Manager; additional guidance can be found at https://www.emedny.org/ProviderManuals/Transportation/index.aspx.

4.20 HCBS NON-MEDICAL TRANSPORTATION

29-I Health Facilities that meet requirements to provide and bill HCBS as outlined in the *Children's Home and Community Based Services Manual* and any subsequent updates.

SECTION 5: POPULATIONS SERVED BY 29-I HEALTH FACILITIES

5.1 CHILDREN/YOUTH IN FOSTER CARE PLACEMENT

Most New York State children and youth in foster care are Medicaid eligible simply by virtue of their foster care status. This includes children/youth who are United States citizens or have satisfactory immigration status.

For more information, please see the following General Information Systems document issued by the Medicaid Program:
https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/05ma041.pdf.

VFCAs may serve children/youth who are not in foster care. 29-I Health Facilities may provide Core Limited Health-Related Services and Other Health-Related Services to the following populations; however, it is not always the responsibility of MMCPs to reimburse for payment for these services, as outlined below and in the chart in Appendix G.

KINSHIP – IN FOSTER CARE CERTIFIED KINSHIP SETTING

Children/youth Enrolled in MMCP

- MMCPs are responsible for paying the Medicaid residual per diem for all days that the enrolled child/youth is enrolled in plan and resides in the certified kinship setting with active Foster Care status until the date of discharge from VFCA or date of disenrollment. This information should be communicated to MMCPs via the transmittal form.
- MMCPs will reimburse for Other Limited Health-Related Services.

Medicaid FFS *(Children/youth NOT Enrolled in MMCP)*

- For the period when the child is enrolled in Medicaid FFS, VFCAs will bill Medicaid FFS the residual per diem rate from the date of admission to the date of discharge and/or change in FC status.
- Medicaid FFS will reimburse for Other Limited Health-Related Services.

KINSHIP – IN FOSTER CARE NON-CERTIFIED KINSHIP SETTING

Children/youth Enrolled in MMCP

- For a child/youth who is enrolled in a MMCP and is placed in a kinship setting that is not certified as a Foster Care setting, the residual per diem cannot be claimed.
- If the kinship placement is certified at a later date, the VFCA can retroactively claim the residual per diem for the Core Limited Health-Related Services up to 90 days. The MMCP will be responsible for the period during which the child/youth was in active Foster Care status, placed in the kinship setting, and enrolled in the MMCP.
- MMCPs will be responsible for reimbursement for Other Limited Health-Related Services.

Medicaid FFS *(Children/youth NOT Enrolled in MMCP)*

- For children/youth who are enrolled in Medicaid FFS and are placed in kinship settings that are not certified as a Foster Care setting, a residual per diem cannot be claimed.
- If the kinship placement is certified at a later date, then the VFCA can claim the residual per diem retroactively up to 90 days. Medicaid FFS will be responsible for the period during which the child/youth was in active Foster Care status, placed in the kinship setting, and enrolled in Medicaid FFS.
- Medicaid FFS will be responsible for reimbursement for Other Limited Health-Related Services to the VFCA provider based on the appropriate fee schedule.

COMMITTEE OF SPECIAL EDUCATION (CSE)[1]

Children/youth Enrolled in MMCP

- For children/youth who are placed with a 29-I Health Facility by their school district's Committee of Special Education (CSE), the school district will reimburse for Other Limited Health-Related Services that are included in the child/youth's Individualized Education Plan (IEP).
- The MMCP will reimburse for Other Limited Health-Related Services that are not listed in the IEP. The MMCP may request the IEP from the child/youth's school district if this information is necessary for care coordination.
- MMCPs are not responsible for covering the residual per diem rates for Core Limited Health-Related Services.

[1] A school placed youth may continue with placement in a 29-I Health Facility past their 21st birthday as outlined in Education Law: Section 4402(5) of NYS Education Law indicates that students with disabilities reaching the age of 21 between July 1 and August 31 are eligible to remain in school until the 31st day of August or until the end of summer program, whichever occurs first. Students turning age 21 between September 1 and June 30 are entitled to remain in school until June 30 or until the end of the school year, whichever comes first.

Medicaid FFS (Children/youth NOT Enrolled in MMCP)

- For children/youth who are placed with a VFCA by the CSE, the school district will reimburse for Other Limited Health-Related Services that are included in the child/youth's IEP.
- Medicaid FFS will reimburse for Other Limited Health-Related Services that are not listed in the IEP.
- Medicaid is not responsible for covering the residual per diem rates for Core Limited Health-Related Services.

When billing for children residing in the 29-I Health Facility and placed by the Committee on Special Education (CSE), the 29-I Health Facility will follow the existing guidance in the Standards of Payment guidance found at https://ocfs.ny.gov/main/rates/assets/docs/SOP-Program-Manual.pdf.

8D BABIES

Children/youth Enrolled in MMCP

- For babies/children of children/youth in foster care (8D babies), the MMCP will reimburse for both Core Limited Health-Related Services and Other Limited Health-Related Services.

Medicaid FFS *(Children/youth NOT Enrolled in MMCP)*

- Medicaid FFS will be responsible for reimbursement for both Core Limited Health-Related Services and Other Limited Health-Related Services.

PRE-DISPOSITIONAL PLACED YOUTH

Children/youth Enrolled in MMCP

- MMCPs are not responsible for covering the residual per diem rates for Core Limited Health-Related Services.
- The MMCP will reimburse for Other Limited Health-Related Services provided by the 29-I Health Facility.

Medicaid FFS (Children/youth NOT Enrolled in MMCP)

- Medicaid FFS will reimburse for Other Limited Health-Related Services provided by the 29-I Health Facility.

OUT-OF-STATE PLACEMENT (NON-TITLE IV-E)

Children/youth Enrolled in MMCP

- Children who are not Title IV-E eligible and are placed out of state are excluded from MMCP enrollment.

Medicaid FFS *(Children/youth NOT Enrolled in MMCP)*

- Medicaid FFS will reimburse for Other Limited Health-Related Services provided by the 29-I Health Facility.
- Medicaid FFS will reimburse for the residual per diem for Core services for days the enrolled child/youth is placed with the 29-I Health Facility.

OUT-OF-STATE PLACEMENT (TITLE IV-E)

MMCP or Medicaid FFS

- Children/youth who are Title IV-E eligible should be enrolled in Medicaid FFS by the state in which the child/youth is residing.
- Core and Other Limited Health-Related Services will be reimbursed in accordance with that state's Medicaid rules.

CHILD HEALTH PLUS (CHPLUS) ENROLLEES

- Children/youth placed in foster care who do not qualify for Medicaid due to immigration status will be enrolled in CHPlus.
- CHPlus plans will reimburse for Core Limited Health-Related Services provided by 29-I Health Facilities in their networks.
- CHPlus plans will reimburse 29-I Health Facilities in their networks for Other Limited Health-Related Services that are covered under the child/youth's CHPlus plan.

5.2 ADULTS OLDER THAN 21, FORMALLY IN FOSTER CARE WHO ARE STILL IN THE CARE OF THE 29-I HEALTH FACILITY

MMCP or Medicaid FFS

- Youth who are 21 years or older may continue to receive Other Limited Health-Related Services if the following circumstances apply:
    - the Enrollee has been placed in the care of the 29-I Health Facility and has been in receipt of Other Limited Health-Related Services prior to their 21st birthday; and
    - the Enrollee has not yet safely transferred to another placement or living arrangement; and
    - the Enrollee and/or their authorized representative is compliant with a safe discharge plan; and
    - the 29-I Health Facility continues to work collaboratively with the MMCP to explore options for the Enrollee's safe discharge, including compliance with court ordered services, if applicable.

Neither MMCPs nor Medicaid FFS will reimburse the residual per diem for Core Limited Health-Related Services after the individual's 21st birthday. Adults over the age of 21 are not eligible for CFTSS or Children's HCBS.

SECTION 6: PROVIDER ASSISTANCE

MMCPs are required to develop and implement provider training and support programs for network providers. This training and support will allow network providers to gain the appropriate knowledge, skills, and expertise, and receive technical assistance to comply with the MMCP's requirements. Training and technical assistance shall be provided to network providers on billing/claims submission, coding, data interface, documentation requirements, and UM requirements.

Network providers shall be informed in writing regarding the information requirements for UM decision making, procedure coding, and submitting claims. MMCPs will provide technical assistance in other areas such as claim submission as indicated by provider performance identified through the quality management and provider profiling programs put in place by the MMCP. MMCPs will ensure providers receive prompt resolution to their inquiries.

6.1 WHERE TO SUBMIT QUESTIONS AND COMPLAINTS

Medicaid Managed Care Billing/claiming questions:
MMCPs will address billing and claiming questions for claims submitted to the MMCP, see your Managed Care contract for additional information.

FFS Billing Questions:
eMedNY Call Center:
1-800-343-9000
https://www.emedny.org
For provider inquiries pertaining to non-pharmacy billing, claims or provider enrollment:
7:30 a.m. - 6:00 p.m. Eastern Time, Monday through Friday (excluding holidays)

For provider inquiries pertaining to eligibility, Point of Service (POS), Dental or Pharmacy claims:
7:00 a.m. - 10:00 p.m., Eastern Time, Monday through Friday (excluding holidays)
8:30 a.m. - 5:30 p.m., Eastern Time, Holidays and Weekends

General eMedNY Information:
P.O. Box 4611
Rensselaer, N.Y. 12144-8611
https://www.emedny.org

Medicaid Managed Care Complaints can be sent to NYS DOH Complaint team at:
1-800-206-8125 or email: managedcarecomplaint@health.ny.gov

Program coverage questions and 29-I licensure questions can be emailed to OCFS and DOH at:
OCFS MAILBOX: ocfs-managed-care@ocfs.ny.gov
DOH MAILBOX: BH.Transition@health.ny.gov

6.2 PRIOR APPROVAL / PRIOR AUTHORIZATION

For Core Limited Health-Related Services (Medicaid residual per diem rate), Medicaid prior approval/prior authorization requirements do not apply. MMCPs may not require prior authorization for Core Limited Health-Related Services or for any mandated Other Limited Health-Related Services assessment for a child/youth in foster care, except as necessary to arrange for out of network services. The mandatory assessments and timeframes are outlined in the 29-I Health Facility guidance, located at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_vfca_health_facilities_license_guidelines.pdf

29-I Health Facilities must have procedures to assure that caseworkers, children/youth, any of their caregivers and others who bring children/youth residing in a 29-I Health Facility to receive

healthcare services in the community effectively communicate to community providers that the child/youth is under the care of the 29-I Health Facility. This will facilitate compliance with both Medicaid billing and Medicaid prior approval/prior authorization requirements that impact claims payment and promote willingness of providers to serve the 29-I Health Facility population.

29-I Health Facility staff that bring children/youth for healthcare services should be directed to supply the healthcare provider with contact information for a 29-I Health Facility Medicaid Managed Care Liaison who can advise providers when it is appropriate to bill the FFS and when it is appropriate to bill the MMCP. This will assist the provider in determining whether Medicaid prior approval/prior authorization requirements must be followed.

Other Limited Health-Related Services that are not mandated as outlined in the 29-I Health Facility Guidance are subject to prior approval/prior authorization and utilization standards set forth by the contract agreement between the 29-I Health Facility and the MMCP.

Prior authorization is not required for Core Health-Related Services and/or mandated assessments. If prior authorization is required and not obtained for services outside of Core Health-Related Services and/or mandated assessments, claims for these services may be denied.

6.3 MEDICAID PRIOR APPROVAL OF ORTHODONTIA CARE FOR MEDICAID FOSTER CARE YOUTH

Orthodontia care is outside the 29-I Medicaid residual per diem and Other Health-Related Services rates, and therefore is billable directly to the Medicaid Program through Medicaid Managed Care Plans or through FFS.

The most current Medicaid FFS prior approval process for orthodontia care must be followed, which is located at https://www.emedny.org/ProviderManuals/Dental/PDFS/Dental_Policy_and_Procedure_Manual.pdf.

Orthodontia Care for non-Medicaid Eligible Youth in Foster Care Enrolled in the Physically Handicapped Children's Program

Prior approval/authorization processes must be followed when Physically Handicapped Children's Program (PCHP)-approved orthodontists render orthodontia care to PHCP-enrolled, non-Medicaid foster care children/youth serviced by VFCA programs. It is expected that these instances will be limited.

Counties vary with response to the scope of their PHCP program, and there are county-specific variations with respect to the programmatic and financial eligibility requirements. Any

questions related to these issues should first be directed to the local county department of health (or other responsible local PHCP entity) in the county whose department of social services has fiscal responsibility for the non-Medicaid foster care children/youth.

6.4 OUT-OF-STATE PROVIDERS

Out-of-state providers can be utilized to serve New York State Medicaid clients only under specific circumstances that are illustrated in New York State Medicaid policy directives. Such information can be found in the Department of Health's *Medicaid Update,* located at health.ny.gov/health_care/medicaid/program/update/main.htm.

Out-of-state providers must enroll in the New York State Medicaid Program in order to bill the Medicaid Program. Further information on the enrollment process for out-of-state providers can be located at Provider Enrollment (emedny.org).

Note: Only Licensed 29-I Health Facilities that are authorized by the New York State OCFS may apply for enrollment in the New York State Medicaid Program and be assigned a Core Limited Health-Related Services (Medicaid residual per diem) rate.

SECTION 7: APPENDICES

APPENDIX A: UTILIZATION MANAGEMENT/MEDICAL NECESSITY GUIDELINES FOR 29-I CORE LIMITED HEALTH-RELATED SERVICES

Medical necessity must be established for Core Limited Health-Related Services and is required for 29-I Health Facilities to bill the Medicaid residual per diem rate. Medical necessity must be determined by one of the following Licensed Practitioners of the Healing Arts (LPHA) operating within the scope of practice:

- Physician
- Psychiatrist
- Psychologist
- Nurse practitioner
- Psychoanalyst
- Registered nurse
- Clinical nurse specialist
- Clinical social worker
- Master social worker
- Marriage and family therapist
- Mental health counselor
- Licensed creative arts therapist

Documentation of medical necessity must include how the Core Limited Health-Related Services are intended to address any of the following:

1. Deliver preventive supports through an array of clinical and related activities including psychiatric supports, information exchange with Medicaid community and skill-building.
2. Reduce the severity of the health issue that was identified as the reason for admission. Provide targeted treatment related directly to the child's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations; safe behavior and appropriate responses to social cues and conflicts; medically appropriate care).

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria 1 AND 2 must be met: 1. Medical necessity must be determined by one of the following Licensed Practitioners of the Healing Arts (LPHA) operating within the scope of practice:	Criteria 1 OR 2 AND 3, 4, & 5 must be met: 1. The child/youth has not fully reached established service goals and there is an expectation that continuation of services will	Any one of the following criteria must be met: 1. The child/youth no longer meets continued stay criteria OR 2. The child/youth is at least 18 years of age and, despite

Admission Criteria	Continued Stay Criteria	Discharge Criteria
• Physician • Psychiatrist • Psychologist • Nurse practitioner • Psychoanalyst • Registered nurse • Clinical nurse specialist • Clinical social worker • Master social worker • Marriage and family therapist • Mental health counselor • Licensed creative arts therapist 2. Addresses the prevention, diagnosis, and/or treatment of overall health (physical and/or behavioral); the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity.	allow the child/youth to make progress OR 2. Continuation of the service is needed to prevent the loss of functional skills already achieved AND 3. The child/youth continues to meet admission criteria AND 4. An alternative service(s) would not meet the child/youth needs AND 5. The treatment plan has been appropriately updated to establish or modify ongoing goals.	multiple attempts on the part of the provider to apply reasonable engagement strategies, has decided to no longer consent to the placement OR 3. The child/youth and/or family/ discharge resource has successfully reached individual/family established service goals and is able to satisfactorily meet the child/youth's overall health care needs.

APPENDIX B: CORE LIMITED HEALTH-RELATED SERVICES RATE CODING TABLE

Level	Description	Facility	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Level 1	General Treatment	Foster Boarding Home	4288	H0041	N/A	Per diem	1/day
Level 2	Specialized Treatment	Therapeutic Boarding Home (TBH)/AIDS	4289	S5145	N/A	Per diem	1/day
		Medically Fragile	4290	S5145	TF		
		Special Needs	4291	S5145	U1		
Level 3	Congregate Care	Maternity	4292	S5145	HD	Per diem	1/day
		Group Home (GH)	4293	S5145	HA		
		Agency Operated Boarding Home (ABH)	4294	S5145	U2		
		Supervised Independent Living Program (SILP)	4295	S5145	U3		
Level 4	Specialized Congregate Care	Group Residence (GR)	4296	S5145	HA, U5	Per diem	1/day
		Diagnostic	4297	S5145	TG		
		Institutional	4298	S5145	U5		
		Hard to Place/Other Congregate	4299	S5145	U6		
		Raise the Age	4300	S5145	U7		

APPENDIX C: OTHER LIMITED HEALTH-RELATED SERVICES RATE CODING TABLE

Rate Code	Unit Limit per Rate Code	Rate Code Description	
4588	24 units/year	Alcohol and Drug Testing	
Billing Unit Measure: 15 minutes			
Service Description		**Modifier**	**Procedure Code**
Alcohol and/or drug screening		U9	H0049
Alcohol and/or drug services, brief intervention, per 15 minutes		U9	H0050
Alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT DAST) and brief intervention (SBI) services 15 to 30 minutes		U9	99408
Alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT DAST) and brief intervention (SBI) services greater than 30 minutes		U9	99409
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4589	48 units/year	Developmental Testing	
Billing Unit Measure: 15 minutes			
Service Description		**Modifier**	**Procedure Code**
Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; **first hour**		U9, SC	96112
Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes		U9, SC	96113

<table>
<tr><th>Rate Code</th><th>Unit Limit per Rate Code</th><th colspan="2">Rate Code Description</th></tr>
<tr><td>4590</td><td>12 units/day</td><td colspan="2">Psychotherapy (Individual and Family)</td></tr>
<tr><td colspan="4">Billing Unit Measure: 15 minutes</td></tr>
<tr><th colspan="2">Service Description</th><th>Modifier</th><th>Procedure Code</th></tr>
<tr><td colspan="2">Psychotherapy, 30 min with child/youth</td><td>U9</td><td>90832</td></tr>
<tr><td colspan="2">Psychotherapy, 45 min with child/youth</td><td>U9</td><td>90834</td></tr>
<tr><td colspan="2">Psychotherapy, 60 min with child/youth</td><td>U9</td><td>90837</td></tr>
<tr><td colspan="2">Family Psychotherapy (without the child/youth) 50 minutes (do not report less than 26 minutes)</td><td>U9</td><td>90846</td></tr>
<tr><td colspan="2">Family Psychotherapy (conjoint psychotherapy with child/youth present) 50 minutes
*Sessions where the child/youth is present may be billed by a 29-I Health Facility if they are at least 8 minutes</td><td>U9</td><td>90847</td></tr>
<tr><th>Rate Code</th><th>Unit Limit per Rate Code</th><th colspan="2">Rate Code Description</th></tr>
<tr><td>4591</td><td>8 units/day</td><td colspan="2">Psychotherapy Group</td></tr>
<tr><td colspan="4">Billing Unit Measure: 15 minutes</td></tr>
<tr><th colspan="2">Service Description</th><th>Modifier</th><th>Procedure Code</th></tr>
<tr><td colspan="2">Multi-Family Group Psychotherapy</td><td>U9</td><td>90849</td></tr>
<tr><td colspan="2">Group Psychotherapy (other than of a Multi-family)</td><td>U9</td><td>90853</td></tr>
<tr><th>Rate Code</th><th>Unit Limit per Rate Code</th><th colspan="2">Rate Code Description</th></tr>
<tr><td>4592</td><td>48 unit/year</td><td colspan="2">Neuropsychological testing/evaluation services</td></tr>
<tr><td colspan="4">Billing Unit Measure: 15 minutes</td></tr>
<tr><th colspan="2">Service Description</th><th>Modifier</th><th>Procedure Code</th></tr>
<tr><td colspan="2">Neuropsychological testing evaluation services by physician or other qualified health care professional, standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, first hour</td><td>U9, SC</td><td>96132</td></tr>
<tr><td colspan="2">Neuropsychological testing evaluation services by physician or other qualified health care professional, standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, each additional hour (list separately) in addition to code for primary procedure</td><td>U9, SC</td><td>96133</td></tr>
</table>

Rate Code	Unit Limit per Rate Code	Rate Code Description
4593	48 units/year	Psychiatric diagnostic examination

Billing Unit Measure: 15 minutes

Service Description	Modifier	Procedure Code
Psychiatric diagnostic examination	U9	90791
Psychiatric diagnostic examination, includes medical services	U9	90792
Psychological or neuropsychological test administration and scoring	U9	96136
Psychological or neuropsychological test administration and scoring/additional 30 minutes	U9	96137
Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data	U9	96130
Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data/additional hour	U9	96131

Rate Code	Unit Limit per Rate Code	Rate Code Description
4594	12 units/day	Office Visit

Billing Unit Measure: 15 minutes

Service Description	Modifier	Procedure Code
Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 8-10 minutes of medical discussion. Do not report 98016 in conjunction with 98000-98015. Do not report services of less than 8 minutes of medical discussion. This is a patient-initiated service.	U9, SC	98016
New Patient Office or outpatient visit (typically 20 minutes) usually presenting problem(s) are low to moderate severity	U9, SC	99202
New Patient Office or outpatient visit (typically 30 minutes) usually presenting problem(s) are moderate severity	U9, SC	99203
New Patient Office or outpatient visit (typically 45 minutes) usually presenting problem(s) are moderate to high severity	U9, SC	99204
New Patient Office or outpatient visit (typically 60 minutes) usually presenting problem(s) are moderate to high severity	U9, SC	99205

Established Patient Office visit (typically 10 minutes) usually the presenting problem(s) are self-limiting or minor	U9, SC	99212
Established Patient Office visit (typically 15 minutes) usually the presenting problem(s) are low to moderate severity	U9, SC	99213
Established Patient Office visit (typically 25 minutes) usually presenting problem(s) are moderate to high severity	U9, SC	99214
Established Patient Office visit (typically 40 minutes) usually presenting problem(s) are moderate to high severity	U9, SC	99215
Preventive Medicine – Initial comprehensive evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; **infant (younger than 1 year)**	U9, SC	99381
Preventive Medicine – Initial comprehensive evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood **(age 1 through 4 years)**	U9, SC	99382
Preventive Medicine – Initial comprehensive evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient**; late childhood (age 5 through 11 years)**	U9, SC	99383
Preventive Medicine – Initial comprehensive evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient**; late childhood (age 12 through 17 years)**	U9, SC	99384
Preventive Medicine – Initial comprehensive evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; **18-39 years**	U9, SC	99385
Established patient periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; **infant (age younger than 1 year)**	U9, SC	99391
Established patient periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; **early childhood (age 1 through 4 years)**	U9, SC	99392

Established patient periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; **late childhood (age 5 through 11 years)**	U9, SC	99393
Established patient periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; **adolescent (age 12 through 17 years)**	U9, SC	99394
Established patient periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; **18-39 years**	U9, SC	99395
Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual **approximately 15 minutes**	U9, SC	99401
Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual **approximately 30 minutes**	U9, SC	99402
Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual **approximately 45 minutes**	U9, SC	99403
Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual **approximately 60 minutes**	U9, SC	99404
Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient **Evaluation and Management** services	U9, SC	99417

Non-Billable Procedure codes applicable to an Office Visit

When billing for an office visit, indicate what services were performed by adding additional non-billable procedure codes to the Office visit claim. Additional non-billable procedure codes will not be reimbursed separately; however, they will provide detail on how complex the visit was and specifically what services were delivered in the billable office visit time period in the claim. When coding the claim, ensure the most accurate coding using appropriate procedure codes based on established definitions in the latest version of ***American Medical Association CPT manual*** with the guidance provided in this document.

Service Description	Procedure Code
Avulsion of nail plate, partial or complete, simple; single	11730
Removal, non-biodegradable drug delivery system	11982
Removal with reinsertion, non-biodegradable drug delivery implant	11983
Removal of foreign body, deep, thigh region or knee area	27372
Insertion of Intrauterine device (IUD)	58300
Removal of Intrauterine device (IUD)	58301
Removal foreign body from external auditory canal; without general anesthesia	69200
Pressurized or non-pressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device	94640
Therapeutic, prophylactic, or diagnostic injection subcutaneous or intramuscular	96372
Service(s) provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g. holidays, Saturday, or Sunday) in addition to basic service	99050
Removal of sutures by physician who did not close the wound	S0630
Peak Expiratory Flow Rate	S8110
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	90863
Medical Nutrition Therapy group (2 or more individuals)	97804
Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]). Effective May 12, 2023, this code is no longer permissible for use in a 29-I setting.	G2023

Rate Code	Unit Limit per Rate Code	Rate Code Description
4595	2 units/day	Smoking cessation treatment

Billing Unit Measure: 15 minutes

Service Description	Modifier	Procedure Code
Smoking cessation treatment (over 10minutes)	U9, SC	99407

Rate Code	Unit Limit per Rate Code	Rate Code Description
4596	12 units/year	ECG

Billing unit measure: one occurrence

Service Description	Modifier	Procedure Code
Rhythm ECG, 12 leads with interpretation report triggered by an event to diagnose – with specific order and documentation in medical record	U9, SC	93000

Rate Code	Unit Limit per Rate Code	Rate Code Description
4597	1 unit/day	Screening-developmental/emotional/behavioral

Billing Unit Measure: one occurrence

Service Description	Modifier	Procedure Code
Developmental screening (e.g. developmental milestone survey, speech, and language delay screen), with scoring and documentation, per standardized instrument	U9, SC	96110
Brief emotional/behavioral assessment (e.g. Depression inventory, attention deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument 15-30 minutes	U9	96127
Administration of patient focused health risk assessment instrument (e.g. health hazard appraisal) with scoring and documentation, per standardized instrument	U9, SC	96160
Administration of caregiver-focused health risk assessment instrument (e.g. depression inventory) for the benefit of the patient, with scoring and documentation per standardized instrument	U9	96161

Rate Code	Unit Limit per Rate Code	Rate Code Description
4598	8 units/day	Hearing and evaluation of speech

Billing Unit Measure: 15 minutes		
Service Description	**Modifier**	**Procedure Code**
Hearing- screening pure test tone air only	U9, SC	92551
Evaluation of speech fluency (e.g. stuttering, cluttering)	U9, SC	92521
Evaluation of speech sound production (e.g. Articulation, phonological process, apraxia, dysarthria)	U9, SC	92522
Evaluation of speech sound production, with evaluation of language comprehension and expression (e.g. Receptive and expressive language)	U9, SC	92523
Behavioral and Qualitative analysis of voice and resonance	U9, SC	92524
Treatment of swallowing dysfunction and/or oral function for feeding	U9, SC	92526

Rate Code	Unit Limit per Rate Code	Rate Code Description
4599	4 units/day	Immunization Administration

Billing Unit Measure: one occurrence		
Service Description	**Modifier**	**Procedure Code**
Administration of FREE vaccine		90460
Administration of vaccine for youth 19 years and older	FB	90471
Actual vaccine/toxoid administered	SL	**Procedure codes for the vaccine/toxoid administered:** Please reference pages 39 – 42 of The New York State Medicaid Program Physician – Procedure Codes Manual, located here.
VFC Guidance https://www.cdc.gov/vaccines/programs/vfc/index.html		

Rate Code	Unit Limit per Rate Code	Rate Code Description
4600	1/day	Laboratory

Billing Unit Measure: one Laboratory procedure		
Service Description		**Procedure Code**
Lithium	U9, SC	80178

Rate Code	Unit Limit per Rate Code	Rate Code Description	
4671	1/day	Laboratory	
Billing Unit Measure: one Laboratory procedure			
Service Description		**Modifier**	**Procedure Code**
Urinalysis, by dip stick or tablet reagent, non-automated, without microscopy		U9, SC	81002
Urinalysis, by dip stick or tablet reagent, automated, without microscopy		U9, SC	81003
Urinalysis; Bacterium scree, except B		U9, SC	81007
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4672	1/day	Laboratory	
Billing Unit Measure: one Laboratory procedure			
Service Description		**Modifier**	**Procedure Code**
Infectious agent antigen detection by immunoassay technique			87426
Multiplex testing: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types a and b, and respiratory syncytial virus, multiplex amplified probe technique			87637
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4673	N/A	Interpreter Services	
Billing Unit Measure: Includes a minimum of eight and up to 22 minutes of medical language interpreter services. These services are billed at a maximum of two billable units of service per patient per encounter; however, if the child/youth is seen for more than one encounter in a day, interpretation services may be billed for up to two units per encounter.			
Service Description		**Modifier**	**Procedure Code**
In person interpreter services			T1013

Telephone interpreter services		GQ	T1013
Rate Code	**Unit Limit per Rate Code**	**Rate code Description**	
4674	1/day	Laboratory	
Billing Unit Measure: one Laboratory procedure			
Service Description		**Modifier**	**Procedure Code**
Urine pregnancy test, by visual color		U9, SC	81025
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4675	1/day	Laboratory	
Billing Unit Measure: one Laboratory procedure			
Service Description		**Modifier**	**Procedure Code**
Hemoglobin; glycosylated (A1C)		U9, SC	83036
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4676	1/day	Laboratory	
Billing Unit measure: one Laboratory procedure			
Service Description		**Modifier**	**Procedure Code**
Blood count; Hemoglobin (HGB)		U9, SC	85018
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4677	1/day	Laboratory	
Billing Unit Measure: one Laboratory procedure			
Service Description		**Modifier**	**Procedure Code**
Antibody; HIV-1		U9, SC	86701
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4678	1/day	Laboratory	
Billing Unit Measure: one Laboratory procedure			
Service Description		**Modifier**	**Procedure Code**
Smear, primary source with Interpretation		U9, SC	87210
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4679	1/day	Laboratory	
Billing Unit Measure: one Laboratory procedure			

Service Description		**Modifier**	**Procedure Code**
Infectious agent detection by nucleic ac		U9, SC	87631
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4680	1/day	Laboratory	
Billing Unit Measure: one Laboratory procedure			
Service Description		**Modifier**	**Procedure Code**
Infectious agent detection by immunoassay		U9, SC	87880
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4681	1/day	Laboratory	
Billing Unit Measure: one Laboratory procedure			
Service Description		**Modifier**	**Procedure Code**
Infectious agent antigen detection by IM (Influenza rapid test)		U9, SC	87804
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4682	1/day	Laboratory	
Billing Unit Measure: one Laboratory procedure			
Service Description		**Modifier**	**Procedure Code**
Molecular PCR Test INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19]), AMPLIFIED PROBE TECHNIQUE			87635
Molecular PCR Test 2019-NCOV CORONAVIRUS, SARS-COV-2/2019-NCOV (COVID-19), ANY TECHNIQUE, MULTIPLE TYPES OR SUBTYPES (INCLUDES ALL TARGETS), NON-CDC.			U0002
Rate Code	**Unit Limit per Rate Code**	**Rate Code Description**	
4683	1/day	Specimen collection SARS- CoV-2	
Billing Unit Measure: one Laboratory procedure			
Service Description		**Modifier**	**Procedure Code**

Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19])		G2023 Effective May 12, 2023, this code is no longer permissible for use in a 29-I setting and is no longer eligible for reimbursement.

Rate Code	Unit Limit per Rate Code	Rate Code Description
4684	1/day	Intradermal Tuberculosis (TB) tests

Billing Unit Measure: one Laboratory procedure

Service Description	Modifier	Procedure Code
All intradermal Tuberculosis (TB) tests, including TB skin tests, TB delayed hypersensitivity tests (DHT or DHR), Mantoux and/or tine tests and the purified protein derivative test (PPD)		86580

Rate Code	Unit Limit per Rate Code	Rate Code Description
4685	N/A	Medical Nutrition Therapy

Billing Unit Measure: 15 Minutes

Service Description	Modifier	Procedure Code
Initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	U9, SC	97802
Medical Nutrition Therapy follow up, re- assessment, and intervention, individual, face-to-face with the patient, each 15 minutes	U9, SC	97803

Rates and Rate codes for Children and Family Treatment and Support Services (CFTSS) can be found here: **https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm**
Rates and Rate codes for Home and Community Based Services (HCBS) can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/manuals.htm

APPENDIX D: MODIFIER DESCRIPTIONS

Use of Modifiers for 29-I Health Facilities Medicaid Residual Per Diem and Fee Schedule

*CPT Modifier **TF** Specialized Treatment (Intermediate care) Medically Fragile*

*CPT Modifier **U1** Medicaid Level 1 Specialized Treatment Special Needs*

*CPT Modifier **HD** (Pregnant/parenting) Congregate Care Maternity*

*CPT Modifier **HA** (Child/adolescent program) Congregate Care Group*

*CPT Modifier **U2** Medicaid Level 2 Congregate Care*

*CPT Modifier **U3** Medicaid Level 3 Supervised Independent Living*

*CPT Modifier **TG** (Complex/high level of care)*

*CPT Modifier **U5** Medicaid Level 5 Specialized Congregate Care*

*CPT Modifier **U6** Medicaid Level 6 Specialized Congregate Care Other*

*CPT Modifier **U7** Medicaid Level 7 Specialized Congregate Care Raise the Age*

*CPT Modifier **U9** Medically Necessary Service*

*CPT Modifier **SC** Medically Necessary Medical Service*

*CPT Modifier **SL** NYS Vaccines for Children*

*CPT Modifier **FB** NYS Vaccines for Youth 19+*

APPENDIX E: REVENUE CODES FOR 29-I HEALTH FACILITY BILLING/CLAIMING

Service	Revenue Code(s)
Alcohol and Drug Testing	0513 – Clinic, Psychiatric clinic
	0520 - Freestanding Clinic, General
	0900 - Behavioral Health Treatments/Services, General
	0914 - Behavioral Health Treatments/Services, Individual therapy
Developmental testing	0513 – Clinic, Psychiatric clinic
	0520 - Freestanding Clinic, General
	0900 - Behavioral Health Treatments/Services, General
	0914 - Behavioral Health Treatments/Services, Individual therapy
	0918 - Behavioral Health Treatments/Services -, Testing
Psychotherapy (Individual and Family)	0513 – Clinic, Psychiatric clinic
	0520 - Freestanding Clinic, General
	0900 - Behavioral Health Treatments/Services, General
	0914 - Behavioral Health Treatments/Services, Individual therapy
	0916 - Behavioral Health Treatments/Services, Family therapy

Service	Revenue Code(s)
Psychotherapy Group	0513 – Clinic, Psychiatric clinic
	0520 - Freestanding Clinic, General
	0900 - Behavioral Health Treatments/Services, General
	0914 - Behavioral Health Treatments/Services, Individual therapy
	0916 - Behavioral Health Treatments/Services, Family therapy
Neuropsychological testing / valuation services	0513 – Clinic, Psychiatric clinic
	0520 - Freestanding Clinic, General
	0900 - Behavioral Health Treatments/Services, General
	0914 - Behavioral Health Treatments/Services, Individual therapy
	0918 - Behavioral Health Treatments/Services -, Testing
Psychiatric diagnostic examination	0513 – Clinic, Psychiatric clinic
	0520 - Freestanding Clinic, General
	0900 - Behavioral Health Treatments/Services, General
	0914 - Behavioral Health Treatments/Services, Individual therapy
Office Visit	0529 - Freestanding Clinic, Other

Service	Revenue Code(s)
Office Visit Preventive Medicine	0770 - Preventive Services, General
Smoking cessation treatment	0513 – Clinic, Psychiatric clinic
	0520 - Freestanding Clinic, General
	0900 - Behavioral Health Treatments/Services, General
	0914 - Behavioral Health Treatments/Services, Individual therapy
ECG	0730 - EKG/ECG Electrocardiogram, General
Screening-developmental/emotional/behavioral	0513 – Clinic, Psychiatric clinic
	0520 - Freestanding Clinic, General
	0900 - Behavioral Health Treatments/Services, General
	0914 - Behavioral Health Treatments/Services, Individual therapy
	0918 - Behavioral Health Treatments/Services -, Testing
Hearing	0529 - Freestanding Clinic, Other
Evaluation of speech	0449 - Speech Therapy Language Pathology, Other
Immunization administration	0771 - Preventive Services, Vaccine administration
Laboratory Services	0300 – Laboratory, General

Service	Revenue Code(s)
	0301 - Laboratory, Chemistry
	0302 - Laboratory, Immunology
	0305 - Laboratory, Hematology
	0306 - Laboratory, Bacteriology and Microbiology
	0307 - Laboratory, Urology
	0309 - Laboratory, Other
	0310 – Laboratory Pathology, General
	0311 - Laboratory Pathology, Cytology
	0312 - Laboratory Pathology, Histology
	0319 - Laboratory Pathology, Other
29-I Clinic services (per diem) Other	0519 – Clinic, Other
	0529 - Freestanding Clinic, Other
Medical Nutrition Therapy	0520 - Freestanding Clinic, General
	0529 - Freestanding Clinic, Other

Behavioral Health Outpatient Revenue Codes

Behavioral Health Outpatient Revenue Codes

APPENDIX F: HCBS SETTINGS OVERVIEW

The CMS Final Rule (§441.301(c)(4) and §441.710) defines the qualities that all home and community-based settings must possess to be in compliance with the rule. In the final rule, CMS also clarifies which settings do NOT qualify as home and community-based settings.

HCBS Settings Rule Resources

The CMS Final Rule on the HCBS Settings Requirement can be found here: https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

CMS has created a Settings Requirements Compliance Toolkit that may be found here: Home & Community Based Services | Medicaid

APPENDIX G: COVERAGE FOR POPULATIONS OUTSIDE OF FOSTER CARE

Medicaid Enrollment/ Placement	**For days in which the child/youth is enrolled in a MMCP**		**For days in which the child/youth is enrolled in Medicaid FFS**		**Commercial/Other Payor**	
Service Type/Fee Schedule	***Other Limited Health-Related Services:***	***Residual Per Diem (Core Health):***	***Other Limited Health-Related Services***	***Residual Per Diem (Core Health)***	***Other Limited Health-Related Services***	***Residual Per Diem (Core Health)***
	Reimbursed based on OLHRS fee schedule or State approved alternate arrangement for the 4-year transition period	Reimbursed at FFS Level/Facility Type rate for the 4-year transition period	Reimbursed based on OLHRS fee schedule	Reimbursed at FFS Level/Facility Type Rate	Reimbursed per subscriber policy; coordination of benefits if child also covered by Medicaid	Reimbursed per subscriber policy; coordination of benefits if child also covered by Medicaid
Foster Care Placement in the care of 29-I in NYS	MMCP pays for OLHRS provided by 29-I	MMCP pays per diem for days enrollee is placed with 29-I	Medicaid FFS pays for OLHRS provided by 29-I	Medicaid FFS pays per diem for days enrollee is placed with 29-I	Commercial/third party insurance carrier pays for covered services, as applicable	Commercial/third party insurance carrier pays for covered services, as applicable
Kinship – certified placement	MMCP pays for OLHRS provided by 29-I	MMCP pays per diem for days enrollee is placed with 29-I	Medicaid FFS pays for OLHRS provided by 29-I	Medicaid FFS pays per diem for days enrollee is placed with 29-I	Commercial/third party insurance carrier pays for covered services, as applicable	Commercial/third party insurance carrier pays for covered services; as applicable. Medicaid FFS/MMC will pay per diem with proof that the benefit is not covered under TPI.

Medicaid Enrollment/ Placement	For days in which the child/youth is enrolled in a MMCP		For days in which the child/youth is enrolled in Medicaid FFS		Commercial/Other Payor	
Kinship – placement not certified	MMCP pays negotiated rates to the provider chosen by the kinship care provider	N/A	Medicaid FFS will reimburse the based on the appropriate fee schedule	N/A	Commercial/third party insurance carrier pays for covered services, as applicable	Commercial/third party insurance carrier pays for covered services, as applicable
CSE	CSE/LDSS pays for OLHRS documented in child's IEP MMCP pays for OLHRS outside child's IEP	N/A Core Health services are included in CSE daily rate (MSAR room and board + per diem) paid by CSE/LDSS	CSE/LDSS pays for OLHRS documented in child's IEP MMCP pays for OLHRS outside child's IEP	N/A Core Health services are included in CSE daily rate (MSAR room and board + per diem) paid by CSE/LDSS	CSE/LDSS pays for OLHRS documented in child's IEP Insurance carrier pays for covered services outside child's IEP	N/A Core Health services are included in CSE daily rate (MSAR room and board + per diem) paid by CSE/LDSS
8D Babies	MMCP pays for OLHRS provided by 29-I	MMCP pays per diem for days the child is placed with the 29-I Health Facility for the reimbursement rate at the program level where the child is placed	Medicaid FFS reimburses for OLHRS provided by 29-I	Medicaid FFS pays per diem for days the child is placed with the 29-I Health Facility for the reimbursement rate at the program level where the child is placed	Commercial/third party insurance carrier pays for covered services, as applicable	Commercial/third party insurance carrier pays for covered services, as applicable

Medicaid Enrollment/ Placement	For days in which the child/youth is enrolled in a MMCP		For days in which the child/youth is enrolled in Medicaid FFS		Commercial/Other Payor	
Pre-dispositional Placed Youth	MMCP pays for OLHRS provided by 29-I	Core Health Services are paid by LDSS	Medicaid FFS reimburses for services provided by the 29-I	Core Health Services are paid by LDSS	Commercial/third party insurance carrier pays for covered services, as applicable	Commercial/third party insurance carrier pays for covered services, as applicable
Out of state placement (non-IV-E)	Excluded from MMCP enrollment	Excluded from MMCP enrollment	Medicaid FFS reimburses for services provided by the 29-I	Medicaid FFS pays per diem for days enrollee is placed with 29-I	Commercial/third party insurance carrier pays for covered services, as applicable	Commercial/third party insurance carrier pays for covered services, as applicable
Out of state placement (IV-E)	To be enrolled Medicaid in the state in which the child is living	To be enrolled Medicaid in the state in which the child is living	To be enrolled Medicaid in the state in which the child is living	To be enrolled Medicaid in the state in which the child is living	Commercial/third party insurance carrier pays for covered services, as applicable	Commercial/third party insurance carrier pays for covered services, as applicable
Former FC Adults older than 21 that are	MMCP pays for services provided by 29-I as long as there is	N/A	Medicaid FFS pays for services provided by 29-I	N/A	Commercial/third party insurance carrier pays for	Commercial/third party insurance carrier pays for

Medicaid Enrollment/ Placement	For days in which the child/youth is enrolled in a MMCP		For days in which the child/youth is enrolled in Medicaid FFS		Commercial/Other Payor	
still in the care of the 29-I	no break in service and the 29-I has documented efforts to safely discharge the adult. Adults over 21 are not eligible for CFTSS or children's HCBS.		as long as there is no break in service and the 29-I has documented efforts to safely discharge the adult. Adults over 21 are not eligible for CFTSS or children's HCBS.		covered services, as applicable	covered services, as applicable
Comprehensive care setting, such as an inpatient setting, nursing facility, RTF, PC, or OPWDD facility	OLHRS are not billable while child is in one of these settings	Per diem is not billable while child is in one of these settings	OLHRS are not billable while child is in one of these settings	Per diem is not billable while child is in one of these settings	OLHRS are not billable while child is in one of these settings	Per diem is not billable while child is in one of these settings
Children under the custody of the juvenile justice system	N/A	N/A	N/A	N/A	N/A	N/A
Child Health Plus (CHPlus) enrollees	N/A	N/A	N/A	N/A	CHPlus pays for covered services, as applicable	CHPlus pays per diem for days enrollee is placed with 29-I

APPENDIX H: CORE AND OTHER LIMITED HEALTH-RELATED SERVICES COVERED UNDER OPTIONAL PHASE 1 LICENSURE OF 29-I HEALTH FACILITY SERVICES

The table below outlines the services that are covered under the Medicaid residual per diem rate for Core Health-Related Services during the Phase 1 Opt-in period.

**Please note that the information referenced in Appendix H was only applicable to the Phase 1 period from 2/1/21 to 7/1/21 and is no longer relevant post-transition on 7/1/21.*

Service listed in eMedNY Provider Manual	Included in Medicaid Residual Per Diem for Core Limited Health-Related Services?	Included in Other Limited Health-Related Services?
Administrative Personnel	**Yes** Administrative staff must be involved in 29-I Health Facility Service delivery for this service to fall under the Medicaid residual per diem.	**No**
Nurse	**Yes** Applies to all nursing services and assessments that can be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) as outlined in the 29-I Health Facility (VFCA transition) (ny.gov)	**No**

Service listed in eMedNY Provider Manual	Included in Medicaid Residual Per Diem for Core Limited Health-Related Services?	Included in Other Limited Health-Related Services?
Practitioner Employed by 29-I: • **Physician Specialist** • **Physician** • **Nurse Practitioner** • **Registered Physician Assistant** • **Psychiatrist** • **Psychologist** • **Clinical Social Worker** • **Marriage and Family Therapist** • **Mental Health Counselor**	**Yes** Clinical consultation/ program supervision services or Skill Building as described in the 29-I Health Facility License Guidelines are included in the Medicaid residual per diem.	**Yes** Encounter-based services outside of Core clinical consultation/program supervision services (e.g. testing/ assessments) may be billed as Other Limited Health-Related Services.
Practitioner/Service Provider *Not* Employed by 29-I: • **Physician Specialist** • **Physician** • **Nurse Practitioner** • **Registered Physician Assistant** • **Psychiatrist** • **Psychologist** • **Ophthalmologist/ Optometrist** • **Clinical Social Worker** • **Marriage and Family Therapist** • **Mental Health Counselor** • **Home Health Care**	**Yes** Non-29-I practitioners must continue to be paid directly by the 29-I Health Facility out of the Medicaid residual per diem, as outlined in the Medicaid Child (Foster) Care Manual available here: https://www.emedny.org/ProviderManuals/ChildCare/PDFS/ChildCare_Policy_Guidelines.pdf	**No**

Service listed in eMedNY Provider Manual	Included in Medicaid Residual Per Diem for Core Limited Health-Related Services?	Included in Other Limited Health-Related Services?
• X-ray/Radiology • Physical Therapy • Occupational Therapy		
Dental	**Yes** Dental providers must continue to be paid through the Medicaid residual per diem, as outlined in the Medicaid Child (Foster) Care Manual available here: https://www.emedny.org/ProviderManuals/ChildCare/PDFS/ChildCare_Policy_Guidelines.pdf	No Dentistry is not an allowable service under the 29-I licensure.
Prescription Drugs and Durable Medical Equipment/Supplies	**No** http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm	**No**
Non-prescription drugs	**No**	**No**
Laboratory	**No**	**Yes**
Transportation	**Yes** Transportation for routine health care services are included in the Core Medicaid residual per diem, as described in this Billing Manual. Non-routine transportation should be billed directly by the transportation provider to Medicaid FFS.	**No**
Speech & Audiology	**No**	**Yes**

Service listed in eMedNY Provider Manual	Included in Medicaid Residual Per Diem for Core Limited Health-Related Services?	Included in Other Limited Health-Related Services?
		Billing guidelines for hearing evaluation and speech are outlined in this Billing Manual.

APPENDIX I: CONTACT INFORMATION

LOCAL DEPARTMENT OF SOCIAL SERVICES

For questions involving:

- Updated and/or corrected Medicaid eligibility and foster care placement status
- Billing roster issues
- Questions and issues
- Locating Medicaid-enrolled health providers, VFCA liaisons, and those delegated to bring foster care youth for health appointments

Local Department of Social Services contact information can be found at:

https://www.health.ny.gov/health_care/medicaid/ldss.htm .

MEDICAID POLICY UNIT

For questions regarding:

- Medicaid policy related to health services covered within the VFCA Medicaid rate or Medicaid fee-for-service

(518) 486-6562

NYS DOH RATE SETTING UNIT

For questions regarding:

- Childcare agency VFCA rate categories
- Medicaid rate setting
- Medicaid cost reporting processes

fostercare@health.ny.gov

NYS DOH ORTHODONTIA POLICY UNIT

(800) 342-3005 Option #2

NYS PHYSICIAN PROFILES WEBSITE

This website includes and specifies both Medicaid-enrolled and non-Medicaid enrolled physicians.

http://www.nydoctorprofile.com/welcome.jsp

OCFS BUREAU OF CHILDREN'S MEDICAID MANAGEMENT

For questions regarding

- VFCA authorization process
- Out-of-state placement
- VFCA program approval, including health care component
- OCFS rate categories; rate setting
- Cost reporting related to the maintenance rate assignment process

(518) 408-4064

OCFS INTERSTATE COMPACT UNIT

For questions regarding:

- Interstate Compact on the Placement of Children

(518) 473-1591

OCFS REGIONAL CONTACTS

For questions regarding:

- Updated eligibility and/or foster care placement status
- Outstanding questions and issues

Only contact the appropriate Regional Office, as indicated on the chart below, after contacting the appropriate local department of social services.

Regional Office	Counties Served	Contact Information
Albany	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	52 Washington St. Rensselaer, NY 12144 **Telephone:** (518) 486-7078 Fax: (518) 486-7625
Buffalo	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	Ellicott Square Building 295 Main Street Room 545, 5th Floor Buffalo, NY 14203 **Telephone:** (716) 847-3145 Fax: (716) 847-3742
New York City	Bronx, Kings, New York, Queens and Richmond	Adam Clayton Powell State Office Bldg. 163 West 125th Street, 18th Floor New York, NY 10027 **Telephone:** (212) 383-1983 Fax: (212) 383-2512
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	259 Monroe Avenue Room 307 Rochester, NY 14607 **Telephone:** (585) 238-8201 Fax: (585) 238-8289

Regional Office	Counties Served	Contact Information
Syracuse	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	The Atrium 100 S. Salina Street Suite 350 Syracuse, NY 13202 **Telephone:** (315) 423-1200 Fax: (315) 423-1198
Yonkers	Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster, Westchester	117 East Stevens Avenue Suite 300 Valhalla, NY 10595

OCFS CENTRAL OFFICE

For questions regarding:

- Outstanding questions and issues

Only contact Central Office after contacting the appropriate regional office.

(518) 408-4064

OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

For questions regarding:

- Processing bills from providers not enrolled in the New York State Medicaid Program
- Health care outside the New York State childcare agency Medicaid rate

(518) 474-7527

ORTHODONTIA PRIOR APPROVAL

For all counties **except** the five boroughs of New York City:

(800) 342-3005 Choose: Option #2

For the five boroughs of New York City:

(212) 978-5560

ONLINE LINKS

To order additional information regarding the Interstate Compact on the Placement of Children, please refer to the American Public Human Services Association publication website: www.aphsa.org.

APPENDIX J: DEFINITIONS

For the purposes of the Medicaid Program, and as used in this Manual, the following terms are defined as follows:

8D BABIES

Babies/children (8D) residing with a parent who is in foster care and receiving services from a 29-I Health Facility

AGENCY OPERATED BOARDING HOME

A level 3 congregate care facility that is a family-type home for the care and maintenance of not more than six children that is operated by a VFCA, in quarters or premises owned, leased, or otherwise under the control of such agency. Such a home may provide care for more than six brothers and sisters of the same family.

COURT-ORDERED SERVICES

Services the Plan is required to provide to enrollees pursuant to orders of courts of competent jurisdiction, provided however, that such ordered services are within the Plan's benefit package and reimbursable under Title XIX of the Federal Social Security Act, SSL 364-j(4)(r).

COMMITTEE ON SPECIAL EDUCATION (CSE) PLACEMENT

Children/youth who are placed in a 29-I Health Facility setting by their local school district’s Committee on Special Education (CSE) for children/youth to receive specialized services (e.g. developmental; behavioral) that cannot be met through the services provided by the local school district.

DIAGNOSTIC

A Level 4 specialized congregate care facility operated by a VFCA for the 24-hour care and maintenance of children and the program has been classified as Diagnostic.

DIRECT CARE FOSTER CARE YOUTH

These youth are served directly by the fiscally responsible local department of social services (LDSS). Most of these youth are placed directly by the LDSS in LDSS-run individual family foster boarding homes. A few are served in other types of foster care group/congregate care type arrangements.

ESSENTIAL COMMUNITY PROVIDERS

Essential Community Providers are, as identified by the State, providers with expertise in serving children placed in foster care. MMCPs will reimburse for covered Benefit Package

services in accordance with the Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract.

FOSTER CARE CHILD/YOUTH

A foster care child/youth is a child/youth who is:

- in the legal custody of the Commissioner of the local department of social services (and in some cases, in the legal custody of the NYS Office of Children and Family Services Commissioner, and assigned foster care status) and
- cared for away from his or her home 24 hours a day in a duly authorized or certified facility or program, including, but not limited to, the following foster care settings:
    - a foster family boarding home,
    - an agency operated boarding home,
    - a group home,
    - a group residence or
    - an institution;

and is:

1. a youth under the age of 18 years; or
2. is between the ages of 18 years and 21 years who entered foster care before his or her 18th birthday and has consented to remain in foster care past his or her 18th birthday, and
    - is a student attending a school, college, or university; or regularly attending a course of vocational or technical training designed to fit him or her for gainful employment; OR
    - lacks the skills or ability to live independently.

Youth in Foster care are sometimes served transitionally on either a short-term or a long-term basis in other service system settings, such as NYS Office for People With Developmental Disabilities licensed settings.

When a youth in foster care who is served under the auspices of a NYS Medicaid-enrolled VFCA is temporarily placed in another service system setting that gets reimbursed by a Medicaid payment methodology, or via a non-Medicaid payment methodology that covers health care costs, then the VFCA must not simultaneously bill their VFCA Medicaid rate.

FOSTER FAMILY BOARDING HOME

A level 1 general treatment facility that is a residence owned, leased, or otherwise under the control of a single person or family who has been certified by a VFCA to care for not more than

six children, and such person or family receives payment from the agency for the care of such children.

GROUP HOME

A level 3 congregate care facility that is a family-type home for the care and maintenance of not less than 7 nor more than 12 children who are at least five years of age, operated by a VFCA, in quarters or premises owned, leased or otherwise under the control of such agency, except that such minimum age is not applicable to siblings placed in the same facility nor to children whose mothers are placed in the same facility.

GROUP RESIDENCE

A Level 4 specialized congregate care facility operated by a VFCA for the care and maintenance of not more than 25 children

HARD TO PLACE

A Level 4 specialized congregate care facility operated by a VFCA for the 24-hour care and maintenance of children and the program has been classified as Hard to Place.

INSTITUTION

A Level 4 specialized congregate care facility operated by a VFCA for the 24-hour care and maintenance of 13 or more children.

KINSHIP

Setting where a child/youth is considered to be in foster care and placed in a relative's home. Kinship providers can be certified 29-I Health facilities or actively pursuing certification.

MATERNITY

A level 3 congregate care facility operated by a VFCA for the 24-hour care and maintenance of children and the program has been classified as Maternity.

MEDICALLY FRAGILE

A level 2 specialized treatment facility that is a residence owned, leased or otherwise under the control of a single person or family who has been certified by a VFCA to care for not more than six children, and such person or family receives payment from the agency for the care of such children.

RAISE THE AGE

A Level 4 specialized congregate care facility operated by a VFCA for the 24-hour care and maintenance of children and the program has been classified as Raise the Age.

SINGLE CASE AGREEMENT (SCA)

An agreement between a non-contracted provider and the MMCO with in which the provider is reimbursed for the care for one specific child's case.

SPECIAL NEEDS

A level 2 specialized treatment facility that is a residence owned, leased, or otherwise under the control of a single person or family who has been certified by a VFCA to care for not more than six children, and such person or family receives payment from the agency for the care of such children.

SUPERVISED INDEPENDENT LIVING PROGRAM (SILP)

A level 3 congregate care facility for youth under the supervision of an authorized VFCA and are intended to provide a transitional experience for children for whom the plan of care is discharge from care to their own responsibility. Youth live in a unit separate from the rest of the agency dwellings. A SILP living unit may house not more than four children; children must be at least 16 years of age and not more than 21 years of age.

THERAPEUTIC/AIDS

A level 2 specialized treatment facility that is a residence owned, leased, or otherwise under the control of a single person or family who has been certified by a VFCA to care for not more than six children, and such person or family receives payment from the agency for the care of such children.

TITLE IV-E

Title IV-E of the Social Security Act (42 U.S.C. §§ 671-679b) provides for federal reimbursement for a portion of the maintenance and administrative costs of foster care for children who meet specified federal eligibility requirements. In New York, the federal share is 50%. The federal funds help offset the State and local costs of providing foster care to children. However, not all children in foster care in New York are eligible for federal Title IV-E reimbursement as per the guidelines located at https://ocfs.ny.gov/main/fostercare/titleiv-e/.

VOLUNTARY FOSTER CARE AGENCY (VFCA)

Any agency, association, corporation, institution, society, or other organization which is

incorporated or organized under the laws of New York State with corporate power or empowered by law to care for, to place out, or to board out children.

The entity must actually have its place of business in New York State and must be approved, visited, inspected, and supervised by the New York State Office of Children and Family Services or submit and consent to the approval, visitation, inspection, and supervision of the New York State Office of Children and Family Services as to any and all acts in relation to the welfare of children performed or to be performed under the provisions of Title 1 of Article 6 of the Social Services Law.

Local departments of social services (LDSS) contract with VFCAs to serve particular youth in foster care, commonly those with more complex health and social service needs.

The New York State Office of Children and Family Services has statutory oversight responsibility, including oversight of health care, for both direct care youth in foster care and those served by VFCAs.