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UPDATED Frequently Asked Questions Regarding Children's Billing Code Changes

Effective December 1, 2023, NYS is implementing a billing change that will allow claims for Children's Home and Community Based Services (HCBS) and Children and Family Treatment Support Services (CFTSS) to be paid based on the county in which services were provided, rather than a provider's corporate headquarters or central office address. This update is necessary to align with the Centers for Medicare and Medicaid Services (CMS) billing requirements, which dictate that services must be reimbursed based on the location of service delivery.

This guidance is not applicable to services found on the 29-I OLHRS services fee schedule. Information on these billing updates, including county FIPS Codes and County Locator Codes, as well as details on electronic and paper claim submissions, can be found here.

General:

1. Is there a list of rate codes that will no longer be in use?
   Answer: None of the CFTSS or HCBS rate codes have changed because of this update.

2. Why is there a need to have a separate process for paper versus electronic claims?
   Answer: The coding varies based on paper or electronic billing due to eMedNY system specifications and separate processes are used today.

3. Will encounters be rejected if providers do not submit new Value Codes in box 40A on the claim?
   Answer: If the required Value Codes are not included on the claim at all, the claim will be rejected. Best practice is to report FIPS/County Locator Value Codes in box 40A of the claim.

4. Who can we contact if the Provider Notice Letter has not yet been received?
   Answer: The go-live date is 12/1/23 so letters are still being sent. If letters have not been received by mid-November, reach out to 1915CR@health.ny.gov ; include your provider name and 8-digit Medicaid billing ID.

5. Do these billing and code changes need to be added to Progress Notes?
   Answer: Since this change is related to billing, the FIPs/County codes do not need to be included in progress notes. However, progress notes should include details on the location of service delivery.

6. Are claims processed through a third-party clearinghouse counted as electronic claims or paper claims?
   Answer: These questions should be directed to the specific vendor that processes claims.

Telehealth Questions

Providers must follow telehealth guidance for the service they are providing, if telehealth is allowable.

7. What county should be used when billing for telehealth?
   Answer: The FIPS/County code used on the claim should be the code associated with the county where the staff member was located during service delivery. If the staff member was located outside of an office location (telecommuting), the county of the agency's administrative office should be included on the claim.

FIPS

8. Is the FIPS table within the guidance final?
   Answer: Yes. Guidance and billing codes can be located at 2023-09-05_bill_req_update_member.pdf (ny.gov) and cftss-hcbs_kids_fips.pdf (ny.gov)

9. How should the value for the county be written?
   Answer: The FIPS Code format for NYS counties is a five-digit code beginning with 36 (e.g., 36###). Please refer to the list of FIPS codes for each county, located here.

10. If a claim for these services is received without a FIPS code, what is the expectation for payment? Pay based on the provider's corporate address, like is currently occurring? Or to deny the claim and request a rebill with the FIPS code?
    Answer:
    i. MMCP Claims: that do not include the required FIPS/County locator code should be denied by MMCPs for dates of service on or after 12/1/2023.
    ii. Fee-for-Service (FFS) Claims: eMedNY is configured to deny FFS claims that lack this information for dates of service on or after 12/1/2023.

11. How are claims that are being readjusted for dates of service before 12/1/23 that may not include the 85/61/FIPS coding to be handled?
    Answer: If a claim is submitted for dates of services prior to 12/1/23 current coding should be utilized. For dates of services on or after 12/1/2023, claims require the FIPS/County locator code information; otherwise, the MMCPs should deny the claim.

12. Do FIPS codes apply to Children's HH?
    Answer: The billing change to reflect the location of service is only applicable to HCBS and CFTSS and does not apply to general Health Home Billing. However, Health Homes billing for HCBS Palliative Care -Counseling and Support Services (Bereavement HH rate codes, 7946, 7947, 7948, 7949, 4950, 4951) would be required to follow this new guidance when submitting claims for dates of services on or after 12/1/23 as this is an HCBS.

13. Within Children's HCBS services, for Palliative Care – Counseling and Support Services:

    • Our understanding of the additions to this benefit, based on the guidance, are that the HCBS provider bills Rate Code 7952 (Bereavement – Assessment/Counseling) and rate Code 8017 (Palliative Care – Counseling and Support Services) and that the Health Home bills Rate Codes 7946-7951 (Bereavement Services). Is this correct?

    Answer: Yes. Health Home claims for this service on or after 12/1/23 must include the appropriate FIPS/County Locator code.

    • If this is correct, are we also correct in assuming that Rate Code 7952 would be subject to the use of the FIPS code? And that Rate Codes 7946 – 7951 would not? Rate Codes 7946 – 7951 already have separate Upstate and Downstate codes outlined in the Billing Manual, and because these are billed by Health Homes, we were assuming that these would not be subject to usage of the FIPS code, even though they are included within the HCBS service array.

    Answer: The Bereavement – Assessment/Counseling 7952, Palliative Care – Counseling and Support Services 8017, and all the Health Home Care Management (Rate codes 7946-7951) will need to be billed the same FIPS/County locator code as all other HCBS. These rates are authorized in the Children's HCBS Waiver.

14. Why is the FIPS code being required?

    Answer: This update is necessary to align with the Centers for Medicare and Medicaid Services (CMS) Medicaid billing requirements, which dictate that services must be reimbursed based on the location of service delivery, instead of a provider's corporate headquarters or central office. The FIPS/County locator codes allow providers to indicate the location of service delivery, which will trigger systems to pay providers accordingly.

15. For services that have a state-wide rate, will the provider still be required to bill FIPS and County Locator Codes?

    Answer: All HCBS and CFTSS rates have upstate and downstate rates.

16. If a session spans multiple counties, can we bill based on start location or are we required to split the session into multiple claims? *For example, a provider begins a Planned Respite session in Richmond County, taking the individual to a community event. The provider then brings the individual to Kings County to join a support group for individuals with his diagnosis. The provider then takes the individual to a park to socialize in Richmond County and ends the session there. Can we use Richmond codes to bill for the session?*

    Answer: For a single service that spans multiple counties, the FIPS code used on the claim in these instances should correspond to the county where the child resides.

17. For sessions that span multiple counties, please also advise if it is different if the session crosses the upstate/downstate line.

Answer: For a single service that spans multiple counties, the FIPS code used on the claim when a service spans multiple counties should correspond to the county where the child resides.

18. If we are designated in one county but take a youth to a location in a county we are not designated in, can we render service in that second county?

    Answer: Providers should be providing services to members that reside in the county the agency is designated to serve. Services should be provided in areas where the agency is designated to provide services. However, there may be instances where an agency may occasionally cross into a county that they are not designated for (i.e., to attend a community event, etc.). In these instances, if the agency happens to provide services in a county that they are not designated for, they would include the county where the child lives on the claim. Agencies are not permitted to provide services in a county they are not designated for on a regular basis. Agencies should request designation in all counties where they expect to provide services on a regular basis.

19. Does the order of the FIPS code matter?

    Answer: It is best practice for the FIPS code to be entered in the 'Value' box for electronic claims as per the screen shot below, and in box 40A for paper claims.

Admission Source: Admission Date: Admission Hour: Discharge Hour:

Medical Record Number:

Prior Authorization Number:

Certification Information

Certification Category | Condition Codes

Value Codes

Code	Value	Code	Value

20. What value code boxes and codes are acceptable?

    Answer:

    When billing electronically - Value code 24 and the rate code are to be entered in field 39A; the rate code is input into the amount field. Value code 85 and the FIPS code are to be entered in field 40A; the 5-digit FIPS code is input into the amount field.

    When billing paper claims - Value code 24 and the rate code are to be entered in field 39A; the rate code is input into the amount field. Value code 61 and the county locator code are to be entered in field 40A.

Codes

	Code	Amount	Value	Value ID		Code	Amount	Value	Value ID
39 A	[illegible]	$8,009.00	0		40 A		$0.00	0	
39 B		$0.00	0		40 B		$0.00	0	
39 C		$0.00	0		40 C		$0.00	0	
39 D		$0.00	0		40 D		$0.00	0	

OK Cancel Help

Medicaid Managed Care Plans (MMCPs)

21. If the provider does not bill the FIPS Code/County Locator Code, is it appropriate to deny claims?

    Answer: Yes, for HCBS and CFTSS claims with date of service on or after 12/1/2023.

22. Is FIPS required for encounter reporting?

    Answer: Yes, FIPS will be required for Plans' encounter reporting.

23. Is the requirement stating that providers must submit claims with the appropriate Value Code + applicable FIPS code/County locator code and MMCPs are to accept claims? OR is the requirement stating that providers must submit claims with the appropriate Value Code + applicable FIPS code/County locator code and MMCPs are to 1) accept the claims and 2) price the claims according to the location as defined by the applicable FIPS code/county locator code.

    Answer: MMCPs will have to accept electronic claims with Value Code 85 + appropriate FIPS code AND paper claims with Value code 61 + appropriate county locator code and pay the provider the correct amount for the county in which services were rendered to the child. The State has different regional amounts (upstate/downstate/rural) for CFTSS and HCBS. Plans will have to ensure the appropriate amount is paid to the provider based on the new FIPS or county locator code used on the claim.

24. Please identify what changes will be necessary for the MMCPs to bill the State for services that are carved out. Please clarify if the changes differ from how MMCPs will receive claims and need to reimburse providers.

    Answer: MMCPs will have to send electronically or on paper the same Value Codes and FIPS or county locator codes that the billers have claimed to your Plan to be reimbursed by NYS.

25. MMCPs expressed they will require 90 days to implement configuration changes. We recommend the State revisit the implementation date.

    Answer: These changes are set to take place on 12/1/23. DOH provided Plans with the 90-day notice through various meetings with MMCPs and Providers in August 2023 and MMCPs were formally notified on September 5, 2023.

Providers' files are already being loaded with the new information needed for the 12/1/23 go-live date.

26. What LOBs does this apply to? CHP? MMC?

    Answer: This billing update is for Medicaid Managed Care Plans including Mainstream Managed Care and HIV Special Needs Plans as well as Fee-for-Service Medicaid for CFTSS and HCBS only.

27. What is the impact of this billing update for non-risk payments to MMCPs for HCBS?

    Answer: MMCPs will need to include applicable FIPS/County locator codes on their non-risk claims to receive payment.

28. Currently we are reimbursing payments on Value and Rate codes. Once this goes into effect, we also have to reimburse to include the 85/61/FIPS coding, which creates some challenges in the amount needing to be configured in the timeframe before go-live 12/1/23. *For example: Providers that serve multiple areas will have to be configured in our system with multiple codes and reimbursement rates. We request 90 days to configure our systems.*

    Answer: MMCPs continue to be required to pay claims based on Value and Rate Codes. This change simply changes the Value Code used for electronic claims to ensure the rate is paid based on where the service was rendered versus where the billing provider's corporate headquarters is located. MMCPs have been given 90 days to configure their systems for this change. There is no additional coding required, and the process is the same.

29. How can Plans best identify which counties a provider is designated for?

    Answer: Plans are sent an Exhibit 4 by OMH each month which includes this information. Additionally, a public facing list of designated Children's HCBS and CFTSS providers along with their county designation is posted here on the DOH Designation webpage, and updated each month. Lastly, this information is found on HCBS and CFTSS providers Formal Designation Letters, which should be shared by providers with Plans during the contracting process and after any updates.

30. Is the recommendation for Plans to only load FIPS codes for counties that providers are approved to provide services in?

    Answer: Plans will need to determine this based on how their individual systems are set up. One suggested approach is to configure systems based on provider designation.

31. What impact will this have on MMCOR reporting and what changes, if any, can we expect?

    Answer: The MMCOR collects data at the service category level and does not differentiate billing locations. Therefore, this billing update will not impact MMCOR reporting.

32. Can the State provide further clarification regarding the need for Palliative Care – Counseling and Support Services codes?

    Answer: All the HCBS Palliative Care services must utilize the FIPS/County Locator Code inclusive of the HCBS Palliative Care -Counseling and Support Services (Bereavement HH rate codes, 7946, 7947, 7948, 7949, 4950, 4951).

Children and Family Treatment and Support Services (CFTSS)

33. How is onsite/offsite billing for CFTSS impacted by this billing update?

    Answer: Services provided will now be reimbursed at the correct amount based upon where they are rendered versus the previous reimbursement method which was based upon the county of the provider's corporate headquarters and/or administrative address.

34. Do the new Billing Requirements apply to all CFTSS claims?

    Answer: All CFTSS are required to utilize the FLIPS/County Locator Codes for dates of service on or after December 1, 2023.

    - **Please note** that claims for CFTSS Crisis Intervention will be move to the OMH Crisis rates sheets once approved by the State's Division of Budget. Once this change is made, Crisis Intervention will not be required to include a FIPS/County locator code. Claims for CFTSS CI will need to include the zip +4 that is associated with the agency's designation letter.

Any additional questions should be submitted to 1915CR@health.ny.gov