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NYS Mainstream Medicaid Managed Care and School-Based Health Center Billing Guidance

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Office of Health Insurance Programs

NYS Mainstream Medicaid Managed Care and School-Based Health Center (SBHC) Billing Guidance

I. Introduction

This guide provides additional clarification for the general billing and payment guidance found in section VI. "SBHC Billing and Reimbursement" of the Department of Health (Department) publication entitled, *Transition of School-Based Health Center Benefit and Population into Medicaid Managed Care*. The guide is applicable to mainstream Medicaid Managed Care Plans (MMC) and HIV Special Needs Plans (HIV SNP) (herein referred to as MMCPs), for services provided to their enrollees by SBHC and SBHC-Dental (SBHC-D) operators.

II. Confidentiality

All MMCPs will ensure appropriate policies and procedures are in place to adhere to the Department's *Policy for the Protection of Confidential Health Information for Minors Enrolled in NYS Medicaid Managed Care Plans*.

III. Billing and Payment of SBHC Services by Service Type

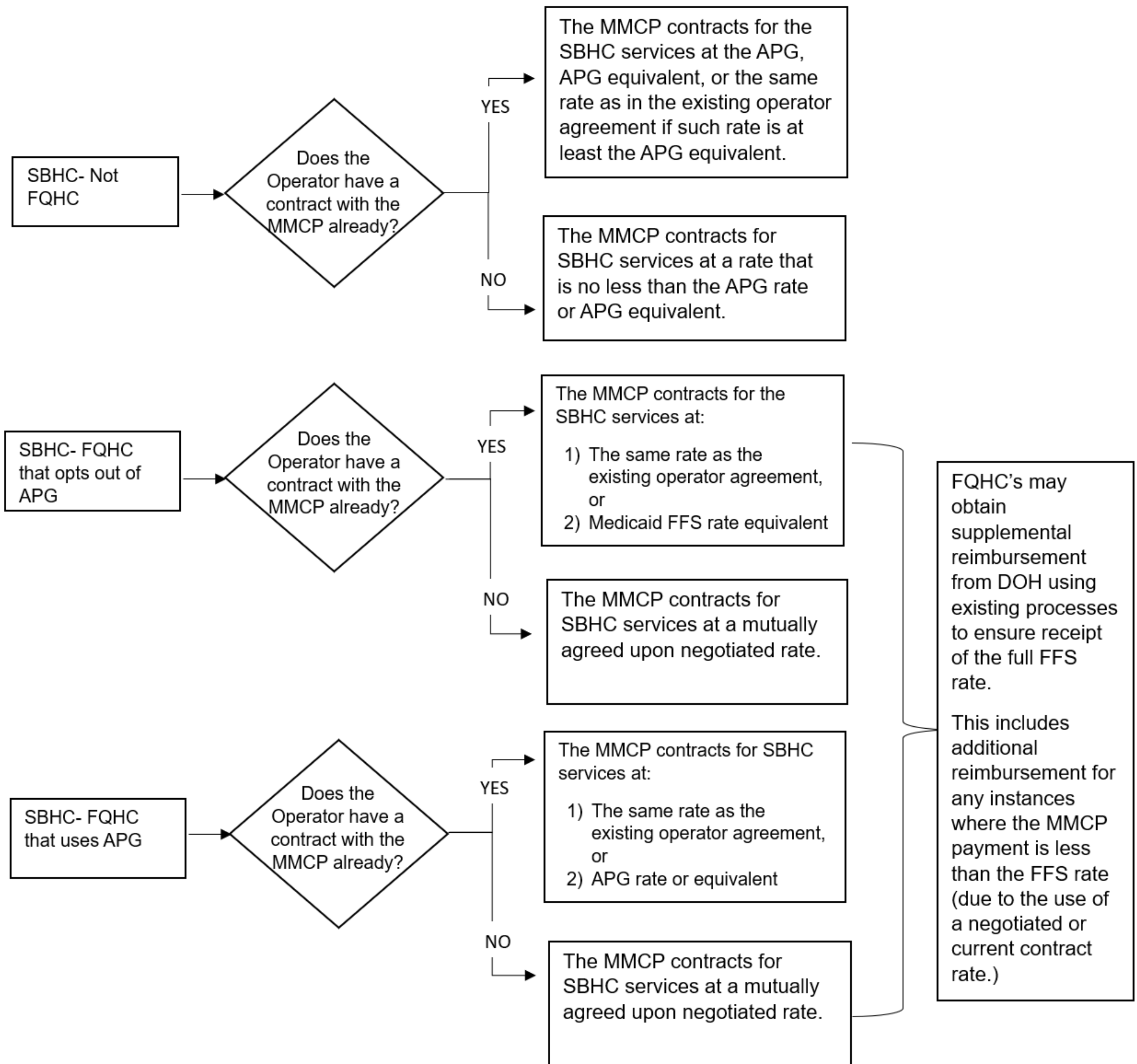
A. Knowing Who to Bill for SBHC Services

For dental and behavioral health benefits managed by an MMCP through a sub-contractual relationship, the SBHC may be required to directly bill the subcontractor as indicated by the MMCP. Claim submission requirements may vary depending on the terms of contracts between MMCPs and SBHC operators.

B. Methods to Address Payment for the Transition Period

The Department intends that the transition of SBHC services to managed care be essentially cost neutral for the operators for a period of at least two (2) years following the transition effective date. To effectuate that goal, the Department requires the MMCP to reimburse the SBHC operators in accordance with how such operators would have been paid by the Medicaid fee-for-service (FFS) program. The claims and billing subgroup has identified that payment in accordance with Medicaid FFS rules can be fulfilled in a number of ways. The following is intended to illustrate the methods that satisfy the Department's intent as it relates to MMCP reimbursement for SBHC services, operated by Federally Qualified Health Centers (FQHCs) and non-FQHCs, and provide flexibility for SBHCs and MMCPs in order to avoid unnecessary systems configuration for both parties. Appendix A provides definitions of key terms used in this document.

Method to Address Payment during the Transition Period



IV. Identification of SBHC Claims

Institutional Claim Identifiers	Paper (UB)	Electronic (837I)
Bill type	089	089
School Health Specific Rate Codes	Box 39 - Amount	L2300; HI01-5
Professional Claim Identifiers*	**Paper (1500)**	**Electronic (837P)**
Place of Service	Value of 03, in Box 24 - B	Value of 03 in L2300; CLM05-1

**Billed only by hospital operated SBHCs when a physician service is performed in the visit.*

V. General Claim Requirements

Every electronic claim submitted to an MMCP, regardless of payment methodology (i.e., Ambulatory Patient Group (APG) or Medicaid FFS/Prospective Payment System (PPS) rate), will require at least the following:

Facility Claims

- Use of the 837i claim form;
- Bill type 089;
- Diagnosis code(s);
- Revenue code(s);
- Medicaid FFS rate code(s);
- Valid procedure (current procedural terminology (CPT) and/or healthcare common procedure coding system (HCPCS)) code(s);
- Procedure code modifiers (as needed);
- Charge; and
- Unit(s) of service.

Professional Claims (where applicable, see also Section IV.)

- Use of 837p claim form;
- Diagnosis code(s);
- Place of service;
- Valid procedure (CPT and HCPCs) code(s);
- Procedure code modifiers (as needed);
- Charge; and
- Units of service.

VI. SBHC APG & Rate Codes

SBHCs are to bill in accordance with the APG manual published by the Department. The table below is excerpted from the APG manual.

Setting/Operator	Service	APG Visit Rate Code	APG Episode Rate Code
Hospital	School-Based Health Center	1444	1450
Free-Standing DTC	School-Based Health Center	1447	1453

Instructions for the submission of claims for Licensed Clinical Social Worker (LCSW), Licensed Masters Social Worker (LMSW), Licensed Mental Health Counselor (LMHC), and Licensed Marriage and Family Therapist (LMFT) services provided on the same day as other SBHC services are as follows:

Rate Codes Established for SBHC Reimbursement for Mental Health Counseling when Provided by a LCSW/LMSW:[1]	
Rate Code	Description
3257	SBHC-LCSW/LMSW service 20-30 minutes with patient
3258	SBHC-LCSW/LMSW service 45-50 minutes with patient
3259	SBHC-Family services LCSW/LMSW with or without patient present

Rate Codes Established for SBHC Reimbursement for Mental Health Counseling when Provided by a LMHC/LMFT:[1]	
Rate Code	Description
3260	SBHC-LMHC/LMFT service 20-30 minutes with patient
3261	SBHC-LMHC/LMFT service 45-50 minutes with patient
3262	SBHC-Family services LMHC/LMFT with or without patient present

For non-FQHCs and FQHCs that utilize APGs a separate mental health counseling claim must be submitted to the MMCP with the appropriate billing codes. The claim will pay at APG under a separate grouper rate.

FQHCs that do not utilize APGs should add mental health counseling service to the medical claim and submit it to the MMCP to pay at the FFS rate or contracted rate.

Vaccine Rate Codes (Administration Only):[2]

Influenza and pneumococcal vaccinations provided at SBHCs are billable using the non-APG rate codes below. Providers are to use the CPT code of the vaccine/toxoid administered with the appropriate rate code to be reimbursed for the administration of influenza and/or pneumococcal vaccines supplied by or available through the Vaccine for Children (VFC) program. No separate or additional vaccine administration CPT code is required.

Vaccine Administration Rate Codes	
Rate Code	Description
1381	SBHC flu seasonal vaccines - administration only
1383	SBHC pneumococcal, vaccines - administration only

SBHCs should bill all other vaccinations utilizing one of the APG rate codes listed above. The provider must append **modifier SL** to the CPT code of the vaccine/toxoid administered (indicating the administration of a vaccine supplied by or available through the VFC program or a vaccine supplied at no cost) to be reimbursed for the administration of the vaccine. Providers should refer to the NYS DOH "NYS APG Modifiers" web page, for current reimbursement rates when appending the **modifier SL**. No separate or additional vaccine administration CPT code is required.

Appendix A Definitions

Fee-for-service (FFS) is a Medicaid payment model where services are unbundled and paid for separately. Health care providers are paid for each service performed (i.e., office visits, laboratory tests, and procedures).

Ambulatory Patient Groups (APGs) is an outpatient Medicaid payment system based upon an Enhanced Ambulatory Patient Group classification system. This system categorizes the amount and type of services across all ambulatory care settings (i.e., outpatient, ambulatory surgery, emergency room and diagnostic and treatment centers). This is a primary payment mechanism under the transition of School-Based Health Centers into Medicaid Managed Care. FQHCs may opt to contract using Prospective Payment System methodology rather than at APG rates.

Prospective Payment System (PPS) is a system in which payment is made for primary health care and qualified preventive services based on a national rate adjusted to the location where services are provided. The national rate is a predetermined fixed amount.

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[1] Medicaid Update; December 2022, Licensed Clinical Social Worker, Licensed Mental Health Counselor, and Licensed Marriage and Family Therapist Service Coverage.

[2] Medicaid Update; October 2024, New York State Medicaid Fee-for-Service Coverage for Vaccinations Administered by Providers.