NEW YORK STATE | Department of Health

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

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Office of Health Insurance Programs

Table of Contents

I. Introduction 2

II. Confidentiality 2

III. Billing and Payment of SBHC Services by Service Type 2

A. Knowing Who to Bill for SBHC Services 2

B. Methods to Address Payments for the Transition Period 2

C. Claims Submission Guidance 3

IV. Identification of SBHC Claims 4

V. General Claim Requirements 4

VI. SBHC APG Rate Codes 5

Appendix A. Definitions 6

Appendix B. Plan and Vendor Table 7

Office of Health Insurance Programs

NYS Mainstream Medicaid Managed Care and School Based Health Center 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 DOH publication entitled, "Transition of School Based Health Center Benefit and Population into Medicaid Managed Care." The guide is applicable to all Medicaid managed care plans (MMCPs), for services provided to their enrollees by school based health center (SBHC) and SBHC-Dental (SBHC-D) providers.

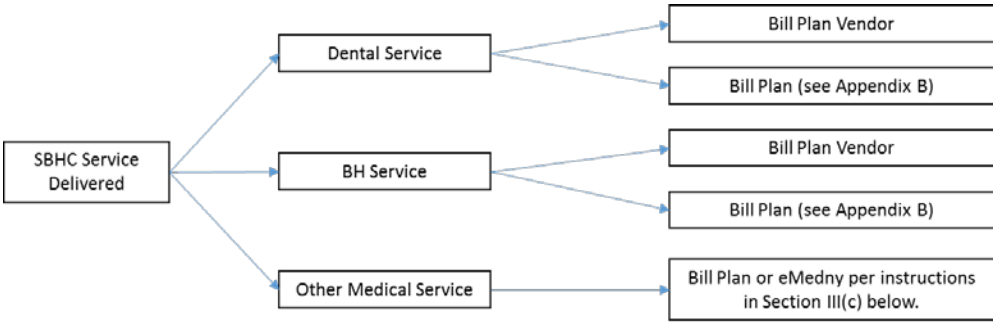
II. Confidentiality

All MMCPs will ensure appropriate suppression of claim denial notices in accordance with the Department of Health'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

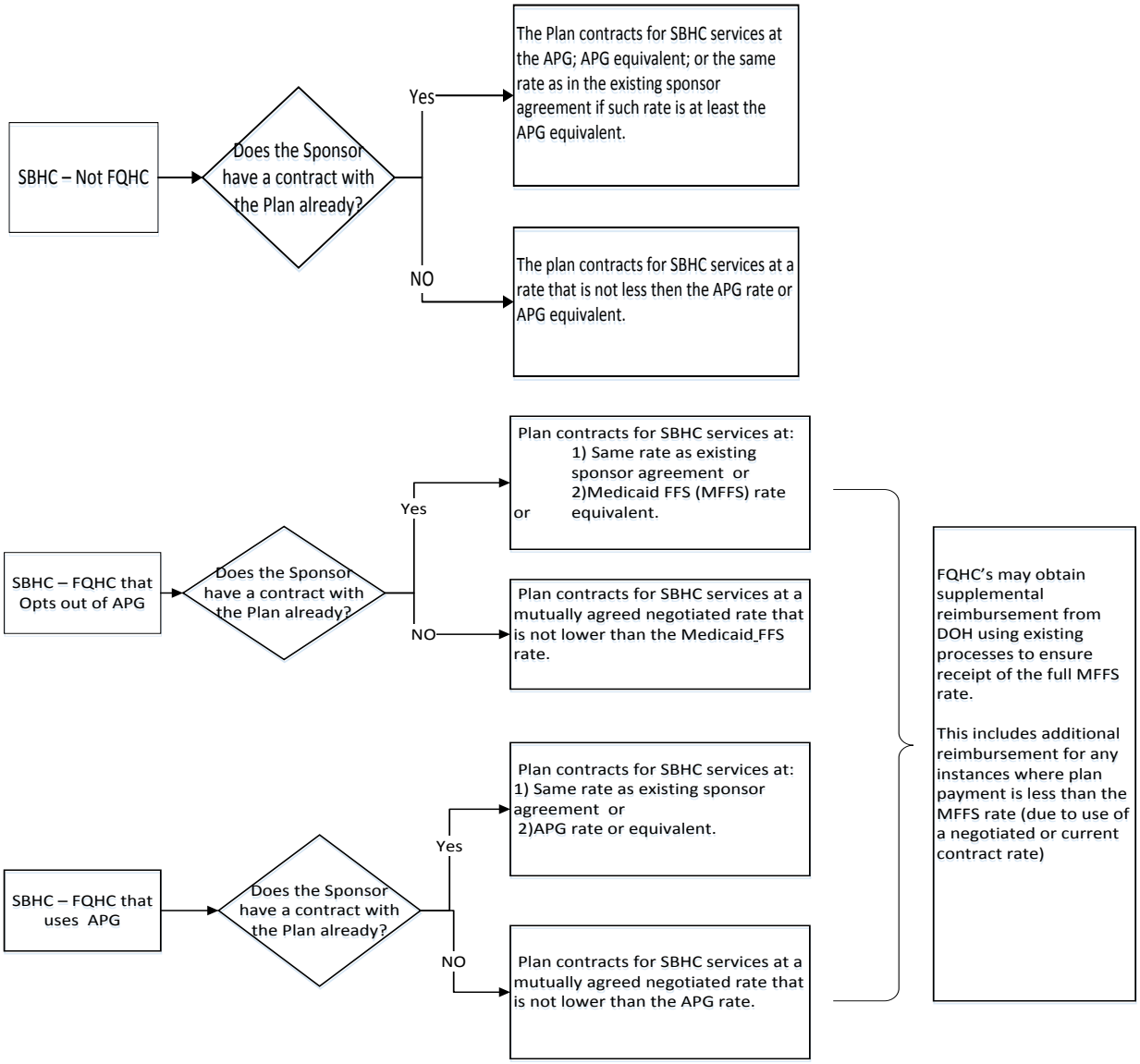
A. Knowing Who to Bill for SBHC Services

The claims and billing subgroup have provided the following graphic to illustrate the appropriate entity to bill for SBHC services as of July 1, 2018. See Appendix B for additional detail.



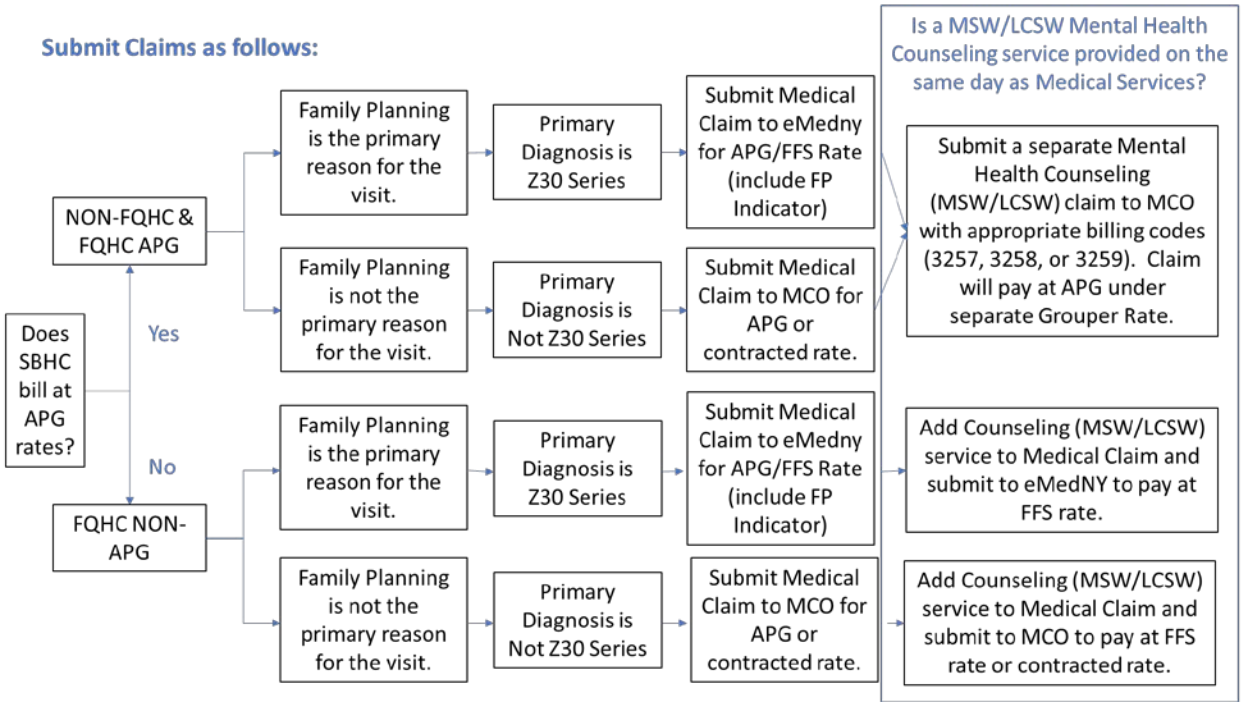
B. Methods to Address Payment for the Transition Period

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



C. Claims Submission Guidance

The diagram below illustrates whether a claim should be submitted via eMedny for FFS payment, or if it should be submitted to the plan (or vendor as appropriate). This diagram provides for Section VI(5) of the transition guidance which states, "Family Planning and Reproductive Health Services delivered at SBHCs will be "carved-out" of the Medicaid Managed Care System…". Instructions for the submission of claims for LCSW/MSW counseling services provided on the same day as other SBHC services are also captured below.



*****For MMCPs that do not include family planning services and reproductive health services in their benefit package, this policy does not preempt or change any procedure implemented to ensure compliance with Appendix C.3 of the Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract.
******Plans may deny claims in which the primary diagnosis is in the Z30 series.

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 sponsored 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., APG or FFS/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 fee for service rate code(s);
- Valid procedure (CPT and/or 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 New York State Department of Health. The table below is excerpted from the APG manual.

Setting/Sponsor	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

Rate codes established for School Based Health Center reimbursement for mental health counseling when provided by a LCSW/LMSW[1].

3257	Individual Brief Counseling (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 20-30 minutes face-to-face visit with the patient)
3258	Individual Comprehensive Counseling (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 45-50 minutes face-to-face visit with patient)
3259	Family Counseling (psychotherapy with or without patient)

Vaccine Rate Codes (Administration Only)

1381	SBHC flu seasonal vaccines - administration only
1382	SBHC flu h1n1 vaccine - administration only
1383	SBHC pneumo, vaccines - administration only

[1] Medicaid Update; June 2011, Medicaid Coverage of Mental Health Counseling by LCSWs and LMSWs Approved for Article 28 Outpatient Hospital Clinics and Free-Standing D&TCs

Appendix A Definitions

Fee-for-service 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)[2] 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).

Prospective Payment System (PPS)[3] 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.

[2] This is a primary payment mechanism under the transition of School Based Health Centers into Medicaid Managed Care. Federally Qualified Health Centers (FQHCs) may opt to contract using Prospective Payment System methodology rather than at APG rates.

[3] This link is for a paper published in August 2001 that provide helpful background information about PPS: https://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf

Appendix B Plan and Vendor Table

Section VI(4) of *Transition of School Based Health Center Benefit and Population into Medicaid Managed Care* states: "For dental and mental health benefits managed by a MMCP through a sub-contractual relationship, the SBHC may be required to directly bill the subcontractor as indicated by the MMCP." Appendix B compiles information provided by Plans identifying where claims will typically be submitted based on the service type. Note: claim submission requirements may vary depending on the terms of contracts between plans and Sponsors.

Plan Name:	Dental Services:	Behavioral Health Services:	All Other Services:	Comments:
Affinity	DentaQuest	Beacon Health Strategies	Affinity Health Plan	Superior Vision is the vendor claims for vision care services should be submitted to.
Amida Care	Vendor	Vendor	AmidaCare	
CDPHP	DentaQuest	CDPHP	CDPHP	
Crystal Run	Healthplex Attn: Claims Dept P.O. Box 9255 Uniondale, NY 11553-9255 Electronic Payer ID: 11271	Beacon Health Options 500 Unicorn Park Drive Suite 103 Woburn, MA 01801 Electronic Payer ID: 43324	Apex Health Solutions (TPA) (Medical Claims) Crystal Run Health Plans PO Box 3630 Akron, OH 44309-3630 Electronic Payer ID: 46120	
Excellus	Healthplex	Excellus Health Plan	Excellus Health Plan	
Fidelis	DentaQuest	FidelisCare	FidelisCare	Davis Vision is our vendor for vision claims.
Healthfirst	DentaQuest	Healthfirst or University Behavioral Associates (UBA) for students who have elected a PCP affiliated with Montefiore Medical Center	Healthfirst	
HealthNow	HealthPlex	Amerigroup	Amerigroup	RX through ESI
HealthPlus	Health Quest	Empire BCBSHP	Empire BCBSHP	Superior Vision for Vision only, if applicable
HIP Emblem	DentaQuest	Beacon Health Options (BHO), The Care Management Organization (CMO)	EmblemHealth, Health Care Partners (HCP), The Care Management Organization (CMO)	For medical claims, some EmblemHealth members may be delegated to either HCP or the CMO in addition to EmblemHealth.

				If a member is delegated to the CMO, then the CMO shall process all medical claims and for BH claims only those from providers directly contracted with the CMO. BH claims for CMO members who see Beacon providers are processed by Beacon.
IHA	Vendor - HealthPlex	Vendor – Beacon Health Options	Plan - IHA	
MetroPlus	Vendor-HealthPlex	Vendor-Beacon Health Options	MetroPlus	
MVP	Health Plex	Beacon Health Options	MVP	
Molina Care (TONY)	HealthPlex	Beacon Health Solutions	Molina Healthcare	Pharmacy-ExpressScripts
United	Vendor – DBP (except any claims that are reimbursable under the APG)	Plan – UnitedHealthcare Community Plan	Plan – UnitedHealthcare Community Plan	Transportation - Logisticare Vision – March Vision
VNSNY	Healthplex	Beacon	VNSNY (CHOICE)	
WellCare	Healthplex	Plan (WellCare)	Plan (WellCare)	Evicore handles certain radiology claims, Superior handles vision claims, CVS handles pharmacy claims
YourCare	Healthplex	Beacon Health Options	YourCare Health Plan	Express Scripts for Pharmacy