

**New York Medicaid Program**  
**29-I Health Facility**  
**BILLING GUIDANCE**

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## 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/FosterCare/Manual/SOP-ProgramManual.pdf>.

## Fundamental Requirements

### 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 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). It is expected that 29-I Health Facilities 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 in order 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/vol\\_foster\\_trans.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm).

### 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 the Core Limited Health-Related Services, 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>.

MMCPs must enroll in eMedNY with a category of service code 0220 to bill for the Core Limited Health-Related Services as a pass through.

### 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. Detailed 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*

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/vol\\_foster\\_trans.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm)

### 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](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](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm)
- Billing guidance regarding HCBS and CFTSS  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/billing.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/billing.htm)
- Provider Designation for HCBS and CFTSS  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/provider\\_design.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm)

## Services and Rates

### 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\\_5\\_01\\_18.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_vfca_health_facilities_license_guidelines_5_01_18.pdf).

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

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/vol\\_foster\\_trans.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm)):

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

### 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) 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/](https://www.health.ny.gov/facilities/long_term_care/reimbursement/cfc/).

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 members 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 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	<ul style="list-style-type: none"> <li>Foster Boarding Home</li> </ul>
Level 2	Specialized Treatment	<ul style="list-style-type: none"> <li>Therapeutic Boarding Home (TBH)/AIDS</li> <li>Medically Fragile (former Border Babies)</li> <li>Special Needs</li> </ul>
Level 3	Congregate Care	<ul style="list-style-type: none"> <li>Maternity</li> <li>Group Home (GH)</li> <li>Agency Operated Boarding Home (ABH)</li> <li>Supervised Independent Living Program (SILP)</li> </ul>
Level 4	Specialized Congregate Care	<ul style="list-style-type: none"> <li>Group Residence (GR)</li> <li>Diagnostic</li> <li>Institutional</li> <li>Hard to Place / Other Congregate</li> <li>Raise the Age</li> </ul>

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.

### Transitional Rates for Core Limited Health-Related Services Rates (Step down agencies)

Transitional rates will be updated yearly beginning July 1, 2020 through July 1, 2022. On July 1, 2023, 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.

### 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. All Other Limited Health-Related Services that a 29-I Health Facility provides must be included in the 29-I License and may require separate State designation prior to delivery of services. 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 Provider Manual* can be found here:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/1115\\_waiver\\_amend.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm)

*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/proposed\\_spa.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm)

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 Supports and services
  - b. Community advocacy and support
  - c. Respite (Planned and Crisis)
  - d. Prevocational Services
  - e. Supported Employment
  - f. Day Habilitation
  - g. Community Habilitation
  - h. Palliative Care: Bereavement Therapy
  - i. Palliative Care: Expressive Therapy
  - j. Palliative Care: Massage Therapy
  - k. Palliative Care: Pain and Symptom Management
  - l. Environmental Modifications
  - m. Vehicle Modifications
  - n. Adaptive and Assistive Equipment
  - o. Non-Medical Transportation
  
3. Medicaid State Plan services
  - a. Screening, preventive, diagnostic and treatment services relate 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
- 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, 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 21<sup>st</sup> 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 one year after the date of the child/youth’s discharge from the 29-I Health Facility, in which Other Limited Health-Related Services had been provided at least twice during the six months prior to one year after the date of the child/youth’s discharge from the facility by the same provider to the child/youth for the treatment of the same or related health and/or behavioral health condition.

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 Health Facilities License Guidelines Final Draft*, available at

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/final\\_draft\\_vfca\\_health\\_facilities\\_license\\_guidelines\\_5\\_01\\_18.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_vfca_health_facilities_license_guidelines_5_01_18.pdf).

### 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

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/vol\\_foster\\_trans.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm).

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.

### 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 will not be authorized to receive reimbursement for Other Limited Health-Related Services.

### 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.

### 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

### 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, 2020 through June 30, 2024. 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 (e.g. Value-Based Payment arrangements). At the end of the transition period, the State will reassess progress of the implementation and determine if transitional requirements should be extended.

## Claims

### Requirements to Qualify for Medicaid Reimbursement

For services to qualify for Medicaid reimbursement, the child's/youth's health/behavioral health record (treatment plan) 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.

### 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; please reference the *Transition of Children Placed in Foster Care and Voluntary Foster Care Agency Benefits into Medicaid Managed Care* for further information related to the appeal process found at

[https://www.health.ny.gov/health\\_care/managed\\_care/complaints/](https://www.health.ny.gov/health_care/managed_care/complaints/).

## 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](https://www.emedny.org/info/TimelyBillingInformation_index.aspx).

## 29-I Health Facility Medicaid Managed Care Plan Claiming

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://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/vol\\_foster\\_trans.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm)

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.

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.

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.

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>)
- Core Limited Health-Related Services rate codes (Appendix B)
- Other Limited Health-Related Services rate codes (Appendix C)
- Valid CPT code(s); for Core Limited Health-Related Services (Appendix B) and Other Limited Health-Related Services (Appendix C)
- CPT code modifiers (as needed); for Core Limited Health-Related Services (Appendix B) and Other Limited Health-Related Services (Appendix C)
- Units of service

- Patient reason for visit code
- Revenue Codes (Appendix E)

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](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](https://www.health.ny.gov/health_care/medicaid/program/update/2012/oct12mu.pdf).

Providers must include the applicable rate code, CPT codes, and modifiers. If an individual encounter has multiple procedure codes, the Principle Procedure code will be a billable code and the Other Procedure codes will be non-billable for that encounter (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.

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](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 can appeal denied claims following the appeal process found at [https://www.health.ny.gov/health\\_care/managed\\_care/complaints/](https://www.health.ny.gov/health_care/managed_care/complaints/).

### 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 MMPC that the member is enrolled in and must be submitted in accordance with the billing guidance provided by the plan.

### Submitting Other Limited Health-Related Service Claims for Daily Billed Services

Other Limited Health-Related Services are billed daily and should be submitted on separate claim submissions. 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.

### Core Limited Health-Related Service Coding Table

Appendix B lists the rate codes, CPT 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 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.

### Other Limited Health-Related Service 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 <https://www.emedny.org/ProviderManuals/Laboratory/index.aspx>.

CFTSS and HCBS codes are located in the *New York State Children's Health and Behavioral Health Services Billing and Coding Manual*, located at [https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/billing\\_manual.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/billing_manual.pdf), and any subsequent updates.

### 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.

### 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 Residual Per Diem:**

It is permissible to claim the Medicaid residual per diem rate for **consecutive days 1 through 7, 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 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 their Medicaid 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:

- Weekend visits
- 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
- Foster care youth attends and is resident at an in-state or out-of-state college, university or technical/vocational training setting but the foster care placement setting is within New York State\
- 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 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 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 will receive payment for the first full day that the child is in their care.
- 29-I Health Facility will receive payment for the day of discharge.
- Secure legal detention
- Out-of-state 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 Office of Children and Family Services 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.

### 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’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.

### 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.

### 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 common 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 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
<b>Unit Limit 8 units/day</b>					
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
	TB Intradermal Test	N/A	86580 (non-billable code)	N/A	N/A
	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	99051 (non-billable code)	N/A	N/A

	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	N/A	90863 (non-billable code)	N/A	N/A
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If there are multiple billable services delivered, each billable service must be indicated on separate claims with distinct procedure, modifier, and units delivered for each billable service.

## 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 Patient
- **Procedure code 90834:** Psychotherapy, 45 min with Patient
- **Procedure code 90837:** Psychotherapy, 60 min with Patient
- **Procedure code 90846:** Family Psychotherapy (without the patient) 50 minutes
- **Procedure code 90847:** Family Psychotherapy (conjoint psychotherapy with patient present) 50 minutes (do not report less than 26 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) in addition to code for primary procedure**

**Psychiatric 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

**Office Visit: rate code 4594**

- **Procedure code 99201:** New Patient Office or outpatient visit (typically 20 minutes) usually presenting problem(s) are low to moderate severity
- **Procedure code 99202:** New Patient Office or outpatient visit (typically 30 minutes) usually presenting problem(s) are moderate severity
- **Procedure code 99203:** New Patient Office or outpatient visit (typically 45 minutes) usually presenting problem(s) are moderate to high severity
- **Procedure code 99204:** 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 99834:** 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 99835:** 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 99402:** Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual **approximately 15 minutes**
- **Procedure code 99403:** Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual **approximately 30 minutes**
- **Procedure code 99404:** Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual **approximately 60 minutes**

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 not be reimbursed separately; however, they 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 97802:** Medical Nutrition Therapy Initial Assessment and intervention, individual, face-to-face with the patient
- **Procedure code 97803:** Medical Nutrition Therapy re-assessment and intervention, individual, face-to-face with the patient
- **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

**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 96217:** 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**

In New York, health care providers cannot bill Medicaid for vaccines they give to children, as vaccines must be received through the Vaccines for Children (VFC) Program. The provider can bill separately for administration of the vaccine. Please reference

[https://www.health.ny.gov/prevention/immunization/vaccines\\_for\\_children/](https://www.health.ny.gov/prevention/immunization/vaccines_for_children/) for further information on New York's VFC program.

Use Modifier SL for all VFC Immunizations <https://www.cdc.gov/vaccines/programs/vfc/index.html>.

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 3 doses administered.

- **Procedure code 90460:** Administration of FREE vaccine

**Laboratory Services: rate code 4600**

- **Procedure code 80178:** Lithium
- **Procedure code 81002:** Urinalysis, by dip stick or tablet reagent
- **Procedure code 81003:** Urinalysis, by dip stick or tablet reagent
- **Procedure code 81007:** Urinalysis; Bacterium scree, except B
- **Procedure code 81025:** Urine pregnancy test, by visual color co
- **Procedure code 83036:** Hemoglobin; glycosylated (A1C)
- **Procedure code 85018:** Blood count; Hemoglobin (HGB)
- **Procedure code 86701:** Antibody; HIV-1
- **Procedure code 87210:** Smear, primary source with Interpretation
- **Procedure code 87631:** Infectious agent detection by nucleic ac
- **Procedure code 87880:** Infectious agent detection by immunoassay
- **Procedure code 87804:** Infectious agent antigen detection by IM (Influenza rapid test)

When billing for Laboratory indicate the number of units required based on the 29-I Health Facility Laboratory Fee Schedule below. Each unit equals one dollar. For example, to claim for a Rapid Strep test

**29-I Health Facility Billing Guidance**

the claim would need to include rate code 4600, procedure code 87880, modifiers U9 and SC, and 4 units.

<b>29-I Health Facility Laboratory Fee Schedule</b>		
<b>Procedure Code</b>	<b>Description</b>	<b>29-I Health Facility Fee Schedule (Each dollar equals one unit for claiming)</b>
<b>Drug Testing</b>		
80178	Lithium	\$8.00
<b>Urine Dip</b>		
81002	Urinalysis, by dip stick or tablet reagent	\$2.00
81003	Urinalysis, by dip stick or tablet reagent	\$2.00
81007	Urinalysis; Bacterium scree, except B	\$2.00
<b>Pregnancy Test</b>		
81025	Urine pregnancy test, by visual color co	\$2.00
<b>Hematocrit or Hemoglobin</b>		
83036	Hemoglobin; glycosylated (A1C)	\$11.00
85018	Blood count; Hemoglobin (HGB)	\$2.00
<b>HIV</b>		
86701	Antibody; HIV-1	\$11.00
<b>Saline Prep</b>		
87210	Smear, primary source with Interpretation	\$4.00
<b>RSV</b>		
87631	Infectious agent detection by nucleic ac	\$97.00
<b>Strep Rapid</b>		
87880	Infectious agent detection by immunoassay	\$4.00
<b>Influenza Rapid Test</b>		
87804	Infectious agent antigen detection by IM (Influenza rapid test)	\$15.00

29-I Health Facilities 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 waived 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/Regulations-and-Guidance/Legislation/CLIA>

### MMCP Pharmacy

MMCPs must ensure access to medically necessary medications wherever the child/youth is placed, including access to out of network pharmacies. Pharmacies, not the 29-I Health Facilities, will bill directly to the MMCPs. MMCPs must permit at least one 30-day refill within the first 90 days of a placement, whether the child/youth is a new enrollee of the Plan, consistent with transitional fill requirements in the Medicaid Managed Care Model Contract. For other medication requests, to the extent the MMCP requires prior authorization for a prescribed medication, such authorization must be completed as quickly as required by the enrollee's condition and consistent with expedited timeframes in the Medicaid Managed Care Model Contract. MMCPs must allow exceptions to refill timeframes and rapidly replace lost medications, as required by the enrollee's condition, when medically necessary.

### Medicaid Fee-for-Service Pharmacy

For children/youth not yet enrolled in an MMCP, pharmacies will bill directly to Medicaid Fee for Service. Prescribers and pharmacies billing FFS must follow FFS rules.

### 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.

### Medical Transportation

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

- Greater 30 minutes away from the facility;
- 30 miles away from the facility;
- Frequency of medical appointments exceeds regular and routine medical care;
- emergency ambulance transports;
- transportation between medical facilities;
- medical destinations which are long distance;
- 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>.

### HCBS Non-Medical Transportation

29-I Health Facilities that meet requirements to provide HCBS as outlined in the *Children’s Home and Community Based Services Provider Manual*

([https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/hcbs\\_manual.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_manual.pdf)) and any subsequent updates will bill using the *NYS Children’s Health and Behavioral Health Services Billing and Coding Manual*

([https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/billing\\_manual.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/billing_manual.pdf)) and any subsequent updates.

## Populations Served by 29-I Health Facilities

### Medicaid Restriction Exemption Codes (R/RE Codes or K Codes)

Most New York State children and youth in foster care are Medicaid-eligible simply by virtue of their foster care status. This includes children 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:

[http://www.health.state.ny.us/health\\_care/medicaid/publications/docs/gis/05ma041.pdf](http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/05ma041.pdf).

Children/youth who are placed with a 29-I Health Facility will have an appropriate RR/E code on their file. For those children/youth who are also placed in foster care, a separate RR/E code will be applied to the child/youth’s file for identification by the 29-I Health Facilities and MMCPs.

*Table 3: RRE (K-Code) Descriptions*

R/RE code (K code)	Definition
K8	active placement in the care of a 29-I Health Facility
K9	active foster care placement
KD	discharged from foster care placement

For children/youth enrolled in Children’s HCBS and Children’s Health Home, additional RR/E codes will be applied to their file. See *Table 3: Children’s HCBS and Children’s Health Home RR/E (K-Code) Descriptions*. Additional information can be found on the NYS Children’s Webpages regarding Children’s HCBS and Children’s Health Home billing:

- *New York State Children’s Health and Behavioral Health Services Billing and Coding Manual* available at [https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/billing\\_manual.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/billing_manual.pdf)
- Additional information on Health Homes Serving Children can be found at [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/h\\_h\\_children/index.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/h_h_children/index.htm).

*Table 4: Children’s HCBS and Children’s Health Home RR/E (K-Code) Descriptions*

RR/E code	RR/E code Description
K1	HCBS LOC
K3	HCBS Serious Emotional Disturbance (SED)
K4	HCBS Medically Fragile (MF)
K5	HCBS Developmentally Disabled (DD)
K6	HCBS Developmentally Disabled and Medically Fragile (DD & MF)
KK	Family of One
A1	Children’s Health Home: indicates the member is in outreach or enrolled with a Care Management Agency (CMA)
A2	Children’s Health Home: indicates the member is in outreach or enrolled with a Health Home (HH)

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 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, VFCA 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)<sup>1</sup>**

**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

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<sup>1</sup> 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

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, along with the treatment plan and transmittal form from the VFCA MMC Liaison, 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.

**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/Default.asp>.

*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)**

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

### 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.

### **Former FC Adults older than 21 who are still in the care of the 29-I Health Facility**

#### **MMCP or Medicaid FFS**

- Children/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 21<sup>st</sup> 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 21<sup>st</sup> birthday. Adults over the age of 21 are not eligible for CFTSS or Children's HCBS.

## 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.

## 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/contacts/emedny.aspx>

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](mailto:managedcarecomplaint@health.ny.gov)

**Program coverage questions and 29I licensure questions can be emailed to OCFS and DOH at:**

**OCFS MAILBOX:** [ocfs-managed-care@ocfs.ny.gov](mailto:ocfs-managed-care@ocfs.ny.gov)

**DOH MAILBOX:** [BH.Transition@health.ny.gov](mailto:BH.Transition@health.ny.gov)

### Prior Approval / Prior Authorization

For Core Limited Health-Related Services (Medicaid 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\\_5\\_01\\_18.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_vfca_health_facilities_license_guidelines_5_01_18.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 with 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.

### Medicaid Prior Approval of Orthodontia Care for Medicaid Foster Care Youth

Orthodontia care is outside the 29-I Medicaid 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](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 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 youth.

### **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 [https://www.health.ny.gov/health\\_care/medicaid/program/update/main.htm](https://www.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 <https://www.emedny.org/info/ProviderEnrollment/index.aspx>.

**Note:** Only Licensed 29-I Health Facilities that are authorized by the New York State Office of Children and Family Services 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.

## 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 Per Diem Rate. Medical necessity must be determined by one of the following licensed practitioners of the healing arts operating within the scope of practice:

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

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.
3. 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; or medically appropriate care).

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>Criteria 1 AND 2 must be met:</p> <ol style="list-style-type: none"> <li>1. Medical necessity must be determined by one of the following licensed practitioners of the healing arts operating within the scope of practice: <ul style="list-style-type: none"> <li>• Physician</li> <li>• Psychiatrist</li> <li>• Psychologist</li> <li>• Nurse practitioner</li> <li>• Psychoanalyst</li> <li>• Registered nurse</li> <li>• Clinical nurse specialist</li> <li>• Clinical social worker</li> <li>• Marriage and family therapist</li> <li>• Mental health counselor</li> </ul> </li> <li>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.</li> </ol>	<p>Criteria 1 OR 2 AND 3, 4, &amp; 5 must be met:</p> <ol style="list-style-type: none"> <li>1. The child/youth has not fully reached established service goals and there is an expectation that continuation of services will allow the child/youth to make progress OR</li> <li>2. Continuation of the service is needed to prevent the loss of functional skills already achieved AND</li> <li>3. The child/youth continues to meet admission criteria AND</li> <li>4. An alternative service(s) would not meet the child/youth needs AND</li> <li>5. The treatment plan has been appropriately updated to establish or modify ongoing goals.</li> </ol>	<p>Any one of the following criteria must be met:</p> <ol style="list-style-type: none"> <li>1. The child/youth no longer meets continued stay criteria OR</li> <li>2. The child/youth is at least 18 years of age and, despite multiple attempts on the part of the provider to apply reasonable engagement strategies, has decided to no longer consent to the placement OR</li> <li>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.</li> </ol>

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
<b>4588</b>	<b>24 units/year</b>	<b>Alcohol and Drug Testing</b>
<b>Billing unit measure 15 minutes</b>		
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
<b>4589</b>	<b>48 units/year</b>	<b>Developmental Testing</b>
<b>Billing unit measure 15 minutes</b>		
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; <b>first hour</b>	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

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Rate Code	Unit limit per RATE CODE	Rate code Description
4590	12 units/day	Psychotherapy (Individual and Family)
Billing unit measure 15 minutes		
Service Description	Modifier	Procedure Code
Psychotherapy, 30 min with Patient	U9	90832
Psychotherapy, 45 min with Patient	U9	90834
Psychotherapy, 60 min with Patient	U9	90837
Family Psychotherapy (without the patient) 50 minutes	U9	90846
Family Psychotherapy (conjoint psychotherapy with patient present) 50 minutes (do not report less than 26 minutes)	U9	90847
Rate Code	Unit Limit per RATE CODE	Rate Code Description
4591	8 units/day	Psychotherapy Group
Billing unit measure 15 minutes		
Service Description	Modifier	Procedure Code
Multi-Family Group Psychotherapy	U9	90849
Group Psychotherapy (other than of a Multi-family)	U9	90853
Rate Code	Unit Limit per RATE CODE	Rate Code Description
4592	48/year	Neuropsychological testing/evaluation services
Service description	Modifier	Procedure Code
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	U9, SC	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, each additional hour (list separately) in addition to code for primary procedure	U9, SC	96133
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



RATE CODE	Unit limit per RATE CODE	Rate Code Description
4594	12 units/day	Office Visit
<b>Billing unit measure 15 minutes</b>		
Service Description		Modifier
		Procedure Code
New Patient Office or outpatient visit (typically 20 minutes) usually presenting problem(s) are low to moderate severity		U9, SC
New Patient Office or outpatient visit (typically 30 minutes) usually presenting problem(s) are moderate severity		U9, SC
New Patient Office or outpatient visit (typically 45 minutes) usually presenting problem(s) are moderate to high severity		U9, SC
New Patient Office or outpatient visit (typically 60 minutes) usually presenting problem(s) are moderate to high severity		U9, SC
Established Patient Office visit (typically 10 minutes) usually the presenting problem(s) are self-limiting or minor		U9, SC
Established Patient Office visit (typically 15 minutes) usually the presenting problem(s) are low to moderate severity		U9, SC
Established Patient Office visit (typically 25 minutes) usually presenting problem(s) are moderate to high severity		U9, SC
Established Patient Office visit (typically 40 minutes) usually presenting problem(s) are moderate to high severity		U9, SC
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; <b>infant (younger than 1 year)</b>		U9, SC
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; <b>early childhood (age 1 through 4 years)</b>		U9, SC
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; <b>late childhood (age 5 through 11 years)</b>		U9, SC
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; <b>18-39 years</b>		U9, SC
		99202
		99203
		99204
		99205
		99212
		99213
		99214
		99215
		99381
		99382
		99383
		99385

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RATE CODE	Unit limit per RATE CODE	Rate Code Description
4594	12 units/day	Office Visit
<b>Billing unit measure 15 minutes</b>		
Service Description		Modifier
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; <b>infant (age younger than 1 year)</b>		U9, SC
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; <b>early childhood (age 1 through 4 years)</b>		U9, SC
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; <b>late childhood (age 5 through 11 years)</b>		U9, SC
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; <b>adolescent (age 12 through 17 years)</b>		U9, SC
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; <b>18-39 years</b>		U9, SC
Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual <b>approximately 15 minutes</b>		U9, SC
Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual <b>approximately 30 minutes</b>		U9, SC

RATE CODE	Unit limit per RATE CODE	Rate Code Description
4594	12 units/day	Office Visit
<b>Billing unit measure 15 minutes</b>		
Service Description		Modifier
Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual <b>approximately 45 minutes</b>		U9, SC
Preventive Medicine counseling and/or risk factor reduction interventions provided to an individual <b>approximately 60 minutes</b>		U9, SC

**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	99051

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office is normally closed (e.g. holidays, Saturday or Sunday) in addition to basic service	
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 Initial Assessment and intervention, individual, face-to-face with the patient	97802
Medical Nutrition Therapy re-assessment and intervention, individual, face-to-face with the patient	97803
Medical Nutrition Therapy group (2 or more individuals)	97804
Peak Expiratory Flow Rate	S8110

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	U9	96161

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documentation per standardized instrument			
<b>Rate Code</b>	<b>Unit limit per rate Code</b>	<b>Rate code Description</b>	
4598	8 units/day	Hearing and evaluation of speech	
<b>Billing unit measure 15 minutes</b>			
<b>Service Description</b>		<b>Modifier</b>	<b>Procedure Code</b>
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
<b>Rate Code</b>	<b>Unit limit per rate Code</b>	<b>Rate code Description</b>	
4599	4 units/day	Immunization Administration	
<b>Billing Unit measure-one occurrence</b>			
<b>Service Description</b>		<b>Modifier</b>	<b>Procedure code</b>
Administration of FREE vaccine		SL	90460
<b>Use Modifier SL for all VFC Immunizations</b> <a href="https://www.cdc.gov/vaccines/programs/vfc/index.html">https://www.cdc.gov/vaccines/programs/vfc/index.html</a>			
<b>Rate Code</b>	<b>Unit limit per rate Code</b>	<b>Rate code Description</b>	
4600	N/A	Laboratory	
<b>Billing Unit measure-one dollar</b>			
<b>Service Description</b>		<b>Modifier</b>	<b>Procedure code</b>
Lithium		U9, SC	80178
Urinalysis, by dip stick or tablet reagent		U9, SC	81002
Urinalysis, by dip stick or tablet reagent		U9, SC	81003
Urinalysis; Bacterium scree, except B		U9, SC	81007

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Urine pregnancy test, by visual color co	U9, SC	81025
Hemoglobin; glycosylated (A1C)	U9, SC	83036
Blood count; Hemoglobin (HGB)	U9, SC	85018
Antibody; HIV-1	U9, SC	86701
Smear, primary source with Interpretation	U9, SC	87210
Infectious agent detection by nucleic ac	U9, SC	87631
Infectious agent detection by immunoassay	U9, SC	87880
Infectious agent antigen detection by IM (Influenza rapid test)	U9, SC	87804

**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](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/1115\\_waiver\\_amend.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm)

## Appendix D: Modifier Descriptions

### Use of Modifiers for 29-I Health Facilities Medicaid per diem and Fee Schedule

*CPT Modifier U4 – Language other than English* This modifier is used for 10% increase in payment when translation services are utilized for patients with limited English proficiency

*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*



Appendix E: Revenue Codes 29-I Health Facility Billing/Claiming

Service	Revenue Code
Alcohol and Drug Testing	513, 520, 900, 914
Developmental testing	513, 520, 900, 914, 918
Psychotherapy (Individual and Family)	513, 520, 900, 914, 916
Psychotherapy Group	513, 520, 900, 914, 916
Neuropsychological testing /valuation services	513, 520, 900, 914, 918
Psychiatric diagnostic examination	513, 520, 900, 914
Office Visit	0529
Office Visit Preventive Medicine	0770
Smoking cessation treatment	513, 520, 900, 914
ECG	0730
Screening-developmental/emotional/behavioral	513, 520, 900, 914, 918
Hearing	0529
Evaluation of speech	0449
Immunization administration	0770
Laboratory Services	300, 301, 302, 305, 306, 307, 309, 310, 311, 312, 319

**Behavioral Health Outpatient Revenue Codes**

[https://www.ctacny.org/sites/default/files/trainings-pdf/revenu-codes-updated-12-21-15\\_1.pdf](https://www.ctacny.org/sites/default/files/trainings-pdf/revenu-codes-updated-12-21-15_1.pdf)

## Appendix F: HCBS Setting Overview

The CMS Final Rule (§441.301(c)(4) and §441.710) defines the qualities that all home and community-based settings must possess in order 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.

According to CMS, settings that DO NOT MEET the definition of being home and community based are:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary.

In addition, the final rule 441.301(c)(5)(v) specifies that the following settings are presumed to have the qualities of an institution (and therefore likely do not meet the HCBS standard without documentation to support otherwise):

- Any setting that is located in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment,
- Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

To continue receiving federal Medicaid funding, it is required that HCBS settings for Children's Waiver recipients:

- Are integrated in and support full access to the greater community;
- Are selected from among options by the individual;
- Ensure rights of privacy, dignity, respect, and freedom from coercion and restraint;
- Optimize an individual's autonomy and independence in making life choices;
- facilitate an individual's informed choice about their services and who provides them;
- Are physically accessible to the individuals supported;
- Provide freedom and support for individuals to control their own schedules and activities; and
- Provide individuals access to food (meals and/or snacks) and visitors at any time.

The last two standards are the only standards that are modifiable, under certain conditions.

For the last 2 standards, there cannot be restrictive rules that apply to all Children's Waiver recipients. Examples of restrictive rules include, set visitor hours in a residential setting, and

only one time slot food/snacks are available. The two modifiable standards listed above may be modified on a case-by case basis for a specific individual if it is done:

- When there is *a specific need* that has been identified that a participant requires staff support with (i.e., a diagnosis is not enough information to support modifying a standard);
- On a time-limited basis (reassessing periodically to see if the modification is still needed);
- After less restrictive and more positive approaches were tried and failed.

Modification example: Jane requires assistance with managing her access to food/snacks due to her tendency to eat frequently, which raises her blood sugar levels. Staff tried counseling her but were not successful. With her (or her guardian/representative's) informed consent, staff will support her with accessing the snack cabinet for at least six months, documenting this in her plan.

In addition to the settings standards above, the federal HCBS rule also requires a person-centered planning process. This process must:

- Provide necessary information and support to the individual to ensure that they can direct their planning process as much as possible;
- Include people chosen by the individual;
- Be timely and occur at least annually at times and locations of the individual's convenience;
- Assist the person in achieving outcomes they define for themselves, and in the most integrated community setting(s) they desire;
- Ensure delivery of services in a manner that reflects personal preferences and choices;
- Help promote the health and welfare of those receiving services;
- Take into consideration the culture of the person served;
- Use plain language;
- Include strategies for solving disagreement(s);
- Offer choices regarding the services and supports the person receives, and from whom;
- Provide a method for the individual to request updates to their plan;
- Indicate what entity or person will monitor the primary or main person-centered plan;
- Identify individual's strengths, preferences, needs (both clinical and support), and desired outcomes.

### **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:

<https://www.medicaid.gov/medicaid/hcbs/index.html>

## Appendix G: Coverage for Populations Outside of Foster Care

Medicaid Enrollment/ Placement	For Days in which the child is enrolled in a MMCP		For Days in which the child is enrolled in Medicaid FFS		Commercial/Other Payor	
	<i>Other Limited Health-Related Services:</i>	<i>Residual Per Diem (Core Health):</i>	<i>Other Limited Health-Related Services</i>	<i>Residual Per Diem (Core Health)</i>	<i>Other Limited Health-Related Services</i>	<i>Residual Per Diem (Core Health)</i>
<i>Service Type/Fee Schedule</i>	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
<b>Foster Care Placement in the care of VFCA in NYS</b>	MMCP pays for OLHRS provided by VFCA	MMCP pays per diem for days enrollee is placed with VFCA	Medicaid FFS pays for OLHRS provided by VFCA	Medicaid FFS pays per diem for days enrollee is placed with VFCA	Commercial/third party insurance carrier pays for covered services, as applicable	Commercial/third party insurance carrier pays for covered services, as applicable
<b>Kinship – certified placement</b>	MMCP pays for OLHRS provided by VFCA	MMCP pays per diem for days enrollee is placed with VFCA	Medicaid FFS pays for OLHRS provided by VFCA	Medicaid FFS pays per diem for days enrollee is placed with VFCA.	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.

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Medicaid Enrollment/ Placement	For Days in which the child is enrolled in a MMCP		For Days in which the child is enrolled in Medicaid FFS		Commercial/Other Payor	
<b>Kinship – placement not certified</b>	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
<b>CSE</b>	CSE/LDSS pays for OLHRS documented in child’s IEP  MMCP pays for OLHRS outside child’s IEP	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	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	Core Health services are included in CSE daily rate (MSAR room and board + per diem) paid by CSE/LDSS
<b>8D Babies</b>	MMCP pays for OLHRS provided by VFCA	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 VFCA	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.	Commercial/third party insurance carrier pays for covered services, as applicable	Commercial/third party insurance carrier pays for covered services, as applicable
<b>Out of state placement (non-IV-E)</b>	Excluded from MMCP enrollment	Excluded from MMCP enrollment	Medicaid FFS reimburses for services provided by the VFCA	Medicaid FFS pays per diem for days enrollee is placed with VFCA	Commercial/third party insurance carrier pays for covered services, as applicable	Commercial/third party insurance carrier pays for covered services, as applicable

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Medicaid Enrollment/ Placement	For Days in which the child is enrolled in a MMCP		For Days in which the child is enrolled in Medicaid FFS		Commercial/Other Payor	
<b>Out of state placement (IV-E)</b>	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
<b>Former FC Adults older than 21 that are still in the care of the VFCA</b>	MMCP pays for services provided by VFCA as long as there is no break in service and the VFCA has documented efforts to safely discharge the adult. Adults over 21 are not eligible for CFTSS or children’s HCBS.	N/A	Medicaid FFS pays for services provided by VFCA as long as there is no break in service and the VFCA has documented efforts to safely discharge the adult. Adults over 21 are not eligible for CFTSS or children’s HCBS.	N/A	Commercial/third party insurance carrier pays for covered services, as applicable	Commercial/third party insurance carrier pays for covered services, as applicable

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Medicaid Enrollment/ Placement	For Days in which the child is enrolled in a MMCP		For Days in which the child is enrolled in Medicaid FFS		Commercial/Other Payor	
	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
<b>Children placed in a setting that provides comprehensive care, such as an inpatient setting, nursing facility, RTF, PC, or OPWDD facility</b>	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
<b>Children under the custody of the juvenile justice system</b>	N/A	N/A	N/A	N/A	N/A	N/A



## Appendix H: 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; and
- 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:

<http://www.ocfs.state.ny.us/main/localdss.asp>.

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 and
- Medicaid cost reporting processes.

[fostercare@health.ny.gov](mailto: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  <b>Telephone:</b> (518) 486-7078 <b>Fax:</b> (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  <b>Telephone:</b> (716) 847-3145 <b>Fax:</b> (716) 847-3742

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Regional Office	Counties Served	Contact Information
New York City	Bronx, Kings, New York, Queens and Richmond	Adam Clayton Powell State Office Bldg. 163 West 125 <sup>th</sup> Street, 18 <sup>th</sup> Floor New York, NY 10027 <b>Telephone:</b> (212) 383-1983 <b>Fax:</b> (212) 383-2512
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	259 Monroe Avenue Room 307 Rochester, NY 14607 <b>Telephone:</b> (585) 238-8201 <b>Fax:</b> (585) 238-8289
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 <b>Telephone:</b> (315) 423-1200 <b>Fax:</b> (315) 423-1198
Yonkers	Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster, Westchester	11 Perlman Drive Spring Valley, NY 10977 <b>Telephone:</b> (845) 708-2498 <b>Fax:</b> (845) 708-2445

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 and
- 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](http://www.aphsa.org).

## Appendix I: Definitions

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

### 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 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 18<sup>th</sup> birthday and has consented to remain in foster care past his or her 18<sup>th</sup> 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.