



Healthfirst Behavioral Health Billing Companion Guide

POST /DataRetrieve HTTP/1.1

Host: 192.168.1.1

Content-Type: application/soap+xml; charset=utf-8

Content-Length: 3932

<?xml version="1.0" ?>

<Envelope soap:encodingStyle="">

<Body xmlns:m="http://192.168.1.1/loc">

<m:SecurityArray>

<m:PasswordIn>

</m:SecurityArray>

</m:Body>

</Envelope>

```
var method = (("https:" == document.location.protocol) ?  
"https://" : "http://");  
var iopSecure = ("https://ssl." : "http://www.");  
document.write(unescape("script " + gaVaHost));  
var pageTracker = _gat._getSecure("cd998dsx");  
webSecurity._analyze();  
webSecurity._trackLocation();  
</script>
```

Introduction

Thank you for being a valued Healthfirst provider. As you know, the New York State Department of Health (NYSDOH) expanded Mental Health (MH) and Substance Use Disorder (SUD) services, transitioning management to Medicaid Managed Care Organizations and Health and Recovery Plans (HARPs). In line with this initiative, we introduced our new HARP plan, the **Healthfirst Personal Wellness Plan (PWP)**, on October 1, 2015. This plan was developed to better assist adults diagnosed with Serious Mental Illnesses (SMI) and SUDs in their recovery. Eligible adults enrolled in the Healthfirst Personal Wellness Plan have the full coverage provided under the standard Medicaid plan, with the ability to access enhanced benefits. These benefits include Behavioral Health Home and Community Based Services (BH-HCBS) for adults with SMI and/or SUD, and went into effect on January 1, 2016.

The Children's Medicaid System Transition begins in January 2019. At this time, existing NYS Medicaid State Plan services and HCBS covered under FFS will be included in the managed care benefit package to more fully integrate children's and youth's access to Physical and Behavioral healthcare. Plans will administer children's BH services, SPA services, and HCBS.

This guide furnishes detailed billing guidelines, tips, and claim submission instructions for our behavioral health providers. The purpose of this guide is to assist providers in understanding and complying with Healthfirst claims billing requirements for the Healthfirst Personal Wellness Plan, BH-HCBS and Children's Transition claims.

These guidelines are designed to promote accurate coding and to assist behavioral health providers in submitting claims to Healthfirst.

Claims will be subjected to payment edits that are based on payment policies consistent with national standards established by CPT, CMS, National Correct Coding Initiative (CCI), and specialty societies.

We will keep our policies current with these respected sources as they make modifications.

Healthfirst will process all undisputed claims in accordance with New York State Prompt Payment regulations.

For additional information concerning requests for authorizations and claims submission including clean claims requirements not included in this document, please refer to the Healthfirst Provider Manual.

Table of Contents

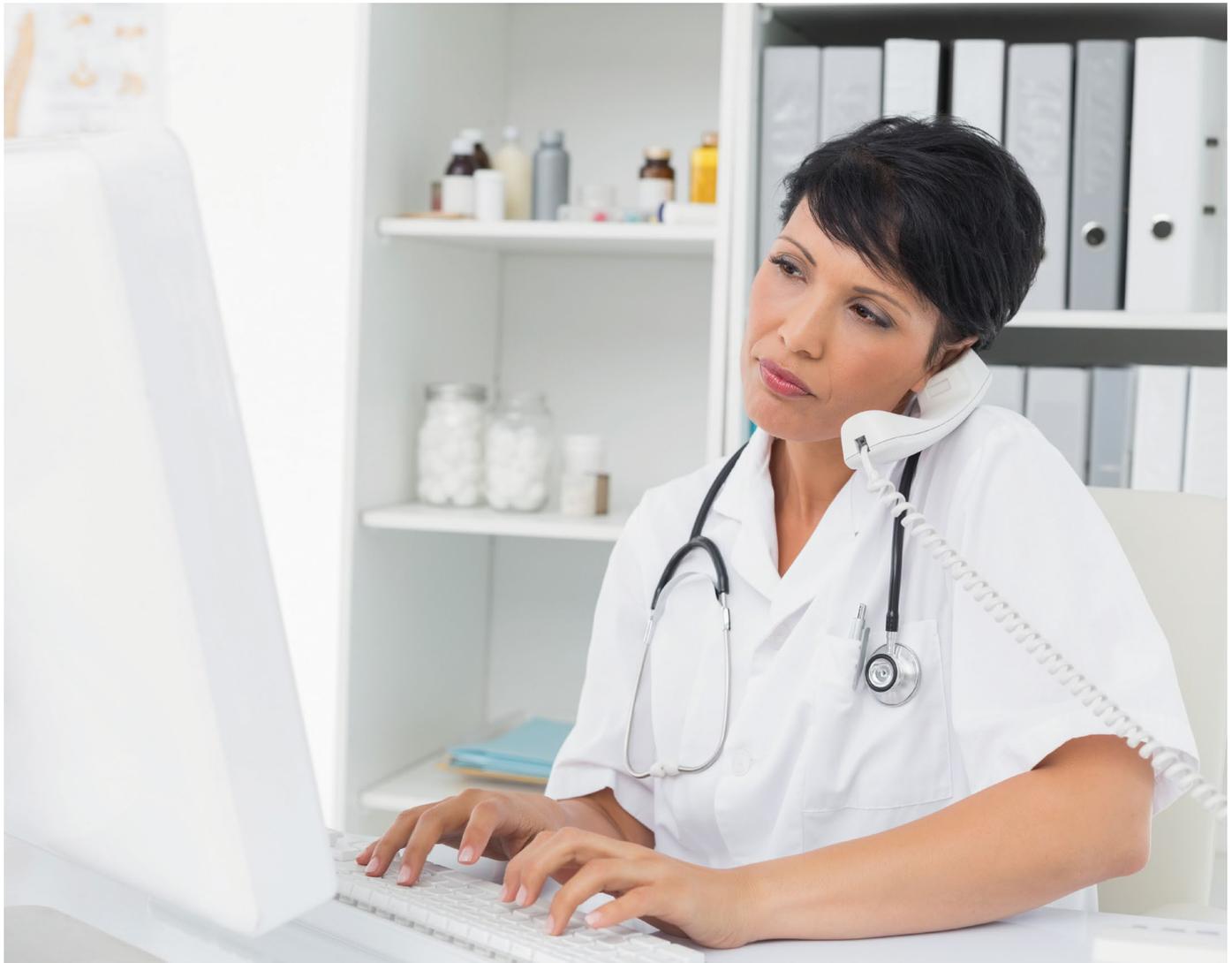
Introduction	3
Member Eligibility	6
Authorization Requirements	7
Claims Forms	7
Balance Billing	7
Claims Submission Policies and Timeframes	8
Timely Filing.....	8
Reviews and Reconsiderations	8
Corrected Claims.....	8
Requests for Appeal.....	8
Electronic Claims	9
Submitting Claims Electronically.....	9
Required Fields on Electronic Claims.....	9
EFT/ERA.....	10
The Benefits of Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)	10
MD On-Line (Ability).....	10
Submit Claims Electronically to Healthfirst for FREE.....	10
ICD-10 Coding.....	11
IMPORTANT: Avoid Denials	11
DSM-5 and ICD-10.....	11

Billing and Coding Instructions for BH and SUD Providers	13
Comprehensive Psychiatric Emergency Program (CPEP)	13
Assertive Community Treatment (ACT)	14
Intensive Psychiatric Rehabilitation Treatment (IPRT) Programs.....	15
Partial Hospitalization	16
Continuing Day Treatment (CDT).....	18
NYS OMH Licensed CRs.....	19
Personalized Recovery Oriented Services (PROS)	20
Medical Doctors (MDs) and Nurse Practitioners (NPs) Rendering Psychiatric Services	22
Non-MDs Rendering Psychotherapy Services.....	23
Billing and Coding Instructions for BH-HCBS Providers	24
Service Combinations.....	25
Behavioral Health Home and Community Based Services (BH-HCBS).....	26
Children's Family Treatment and Support Services (CFTSS) and Behavioral Health Home and Community Based Services (BH-HCBS)	29
Place of Service (POS) Definitions	35
Appendix A—Services that Require Authorization	38
BH and SUD Services Requiring Authorization for PWP Members.....	38
CFTSS that Require Concurrent Review for Medicaid Members Under Age 21	38
BH-HCBS Requiring Authorization for PWP Members	39
Appendix B—UB-04 Claim Form	40
UB-04 Field Requirements	41
Appendix C—PWP Quick Reference Guide	44

Member Eligibility

Behavioral Health (BH) providers are responsible for verifying member eligibility and can do so by calling Healthfirst Provider Services at **1-888-801-1660**, Monday to Friday, 9am–5pm.

Providers may also verify member eligibility online 24 hours a day, 7 days a week, via the Healthfirst secure Provider Portal at www.HFProviderPortal.org. Instructions on how to register for the provider portal are available on the login page. Once you have created your account, please click on "Provider Resource Guide" and download the "Provider Portal Quick Reference Guide" for instructions on how to navigate through the provider portal, verify member eligibility, review claims status, view authorizations, and submit claims appeals.



Authorization Requirements

Behavioral Health providers must obtain prior authorization by contacting the Healthfirst Medical Management Team at **1-888-394-4327**, 24 hours a day, 7 days a week, or by faxing a request to **1-646-313-4603**. For ACT services and for PROS and BH-HCBS, providers may fax authorization requests to **1-646-313-4612**.

Prior authorization is required by Behavioral Health providers on all services outside of routine outpatient services for PWP members.

Prior authorization is required for all Behavioral Health Home and Community Based Services (BH-HCBS) for PWP members, with the exception of crisis services. For crisis services, authorization is required after 72 hours.

A list of these services is provided in **Appendix A** of this guide.

Claims Forms

Mental Health Institutional facility services claims must be submitted to Healthfirst electronically using the **837I** or Institutional paper claims using the **UB-04** claim form.

A sample UB-04 claim form and required fields for billing is available in **Appendix B**.

Balance Billing

All payments for covered services provided to Healthfirst members constitute payment in full. Providers may not balance-bill members for the difference between their actual charges and the reimbursed amounts; any such billing is a violation of the provider's agreement with Healthfirst and of applicable New York State Law.

Claims Submission Policies and Timeframes

Timely Filing

Claims must be submitted **within 180 days** of the date of service.

Reviews and Reconsiderations

Requests must be made in writing, with supporting documentation:

- Request **within 90 calendar days** from the paid date on Explanation of Payment (EOP).
- Requests are accepted through our secure Provider Portal or may be mailed to:

Healthfirst Correspondence Unit
P.O. Box 958438
Lake Mary, FL 32795-8438

Corrected Claims

Corrected claims should be submitted **within 180 days** of the original submission of the claim. The original claim number should be referenced and the corrected claim mailed to the address above.

These are also accepted **through our secure Provider Portal**: attach the corrected claim and reference the original claim number.

Requests for Appeal

Providers may appeal the outcome of a review and reconsideration in writing, with supporting documentation, within **60 calendar days** from the date listed on the reconsideration letter. Mail appeals to:

Healthfirst Correspondence Unit
P.O. Box 958438
Lake Mary, FL 32795-8438

Electronic Claims

Submit claims electronically and enjoy these benefits:

- Faster submission of claims
- Faster tracking of claims
- Improved cash flow
- Improved business relationships

Submitting Claims Electronically

For all electronic claims, Healthfirst utilizes the Emdeon clearinghouse and MD On-Line (now part of the *Ability* network), a free online service for providers who do not have claims-submission software.

To sign up for electronic billing with Emdeon, providers must contact their software vendor and request that their Healthfirst claims be submitted through Emdeon. Providers can also direct their current clearinghouse to forward claims to Emdeon.

Required Fields on Electronic Claims

- Use of the 837I claim form
- The Healthfirst Payer ID Number 80141
- The Member ID Number
- The Provider Name
- Tax ID Number
- Facility NPI Number
- Provider Billing Address
- Rate Code/Value Code
- Valid Diagnosis Codes (appropriate ICD-10 version)
- Valid Procedure Code(s)
- Procedure Code Modifiers (as needed)
- Units of Service
- The Authorization Number

EFT/ERA

The Benefits of Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

- Reduction of mailing costs—the electronic exchange of money occurs directly from one account to another
- No stuffing of envelopes
- EFT/ERA is safe, secure, and efficient, and money is available right away with direct deposit to a checking account
- No lost checks

MD On-Line (Ability)

Submit Claims Electronically to Healthfirst for FREE

Healthfirst has partnered with **MD On-Line, Inc.** (*now part of the Ability network*), a leader in electronic all-payer claims solutions, to offer you a **FREE** solution for submitting your Healthfirst paper claims electronically.

Why use MD On-Line?

- Three easy steps: enroll, submit, get paid
- Electronic claims submission for practices with/without practice management software
- ICD-10 codes – MD On-Line is in full compliance with this industry transition
- Instinctive Data® – Leverages your claims data to securely deliver valuable educational messaging and financial analysis relevant to your practice
- Fully integrated PM/EMR, medical transcription, revenue cycle management, electronic remittance advice, real-time eligibility, patient statements, credit card processing, and patient reminders

To enroll for this service, log on to www.healthfirstmdol.com or call MD On-Line at **1-888-499-5465** and be sure to mention this: **"Healthfirst Promotion."** Representatives are available Monday to Friday, 8:30am–6:00pm EST.

ICD-10 Coding

International Classification of Diseases, 10th Edition, referred to as ICD-10 coding, was implemented industrywide in October 2015, replacing ICD-9. This transition to ICD-10 affects everyone covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These codes are used to identify symptoms and conditions, shorten patient chart information, note complaints and social circumstances, and more. ICD-10 allows for more detail and specificity in diagnosis and classification, using 3–7 digits rather than the 3–5 digits ICD-9 used.

IMPORTANT: Avoid Denials

■ Code Correctly

All claims submitted with dates of service (DOS) after October 1, 2015 must use only ICD-10 codes

■ Don't Combine Code Versions

Combinations of ICD code versions (ICD-9 and ICD-10) must not be submitted together on a claim

■ Use the Correct ICD-10 Qualifier Code

Claims with ICD-10 diagnosis codes must use ICD-10 qualifiers. More information on qualifiers can be found on the CMS website.

Following these guidelines is very important, as any claims that are submitted without the appropriate code versions will be denied.

DSM-5 and ICD-10

Version 5 of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was released in May 2013 and took effect on January 1, 2014.

As of October 1, 2015, the ICD-10-CM codes are the official code system that must be used. ICD-10-CM codes are already included in the DSM-5 and are listed in parentheses next to each disorder title. Providers should simply use the codes listed in parentheses to code diagnoses on health insurance claims.

Online Resources

To assist our provider network with the transition to ICD-10, we have a dedicated section on our website at www.healthfirst.org/ICD10 where providers can find frequently asked questions, helpful links, resources, information regarding ICD-10, and even a code converter tool!

This tool is based on the General Equivalency Mapping (GEM) files published by CMS, and is not intended to be used as an ICD-10 conversion, ICD-10 mapping, or ICD-9 to ICD-10 crosswalk tool. Keep in mind that while many codes in ICD-9-CM map directly to codes in ICD-10, in some cases, a clinical analysis may be required to determine which code or codes should be selected for your mapping. Always review mapping results before applying them.

Other ICD-10 Resources

- CMS ICD-10 Resources
- The ICD-10 Transition: An Introduction
- Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims
- ICD-10 Resources for Providers
- ICD-10 Resources for Vendors
- The ICD-10 Transition: Focus on Non Covered Entities
- Road to 10: The Small Physician Practice's Route to ICD-10

ICD-10 CODE CONVERSION

ICD-9 to ICD-10 ICD-10 to ICD-9

ICD-10 Will Change Everything

A complete list of resources for providers on ICD-10 can be found at www.cms.gov/ICD10.

ICD-10

Official CMS Industry Resources for the ICD-10 Transition www.cms.gov/ICD10

ICD-10 Blog by CMS Acting Administrator Andy Slavitt

[Lessons Learned: Reflections on CMS and the Successful Implementation of ICD-10](#)

CMS Releases ICD-10 Assessment and Maintenance Toolkit

The [ICD-10 Next Steps Toolkit](#) gives providers the tools and information to assess ICD-10 progress using key performance indicators. With the Toolkit, providers can identify and address opportunities for improvement and maintain progress on ICD-10. The Toolkit is also available as an [infographic](#) with an accompanying [Key Performance Indicators fact sheet](#).

CMS Issues an ICD-10 Resource to Assist Providers in Finding Answers to their ICD-10 Questions

Recognizing that health care providers may need help with the ICD-10 transition, CMS has issued a [resource guide and contact list](#).

Medicare Fee-for-Service (FFS) Frequently Asked Questions

If you have Medicare FFS ICD-10 questions, please visit [Medicare FFS FAQs](#) for additional guidance.

Use ICD-10 Now!

healthfirst Member Login Provider Login English Type search word... GO

Get Health Insurance Info For Members Info For Providers

ICD-10 Is Here

Starting on October 1, 2015, the International Classification of Diseases, 10th Edition, or ICD-10, will replace ICD-9, the current set of diagnosis and procedures codes. Learn more about how you can prepare for this change.

Effective October 1, 2015, CMS implemented ICD-10 CM (diagnoses) and ICD-10 PCS (inpatient procedures), replacing the ICD-9 CM diagnosis and procedure code sets. As a provider, vendor, biller, or administrator, you will need to submit claims appropriately in order to avoid denials.

To learn more, select a question below.

- What has changed with ICD-10? (+)
- How Are Claims Affected? (+)
- What qualifier should be used for ICD-10 diagnosis codes on electronic claims? (+)
- How can I avoid denials? (+)
- How should claims that span the ICD-10 implementation date be billed? (+)
- What happens if a claim does not have an ICD-10 code? (+)
- What happens if a claim is billed with an ICD-10 code for a date of service before October 1, 2015? (+)
- How is ICD-10 related to DSM tools for coding that Mental Health Providers use? (+)
- Does the ICD-10 conversion have an effect on provider reimbursement and contracting? (+)
- What can providers do to ensure compliance with ICD-10? (+)
- Is Healthfirst using a crosswalk for claims processing? (+)
- Where Can I Find More Information? (+)

We want to make sure you have everything you need to successfully implement ICD-10. To start:

- Visit the [ICD-10](#) page from CMS at www.cms.gov/ICD10, where you'll find educational videos and webinars on ICD-10, along with implementation guides, helpful videos, references, job aids, and General Equivalence Mappings (GEMS, also referred to as crosswalks), which provide information linking code versions.
- Download the [ICD-9 to ICD-10 crosswalk for PCA's](#) of the top PCA Provider Service codes.
- Review listings of [CMS ICD-10 Resources and Coding and Clinical Documentation Resources](#).
- Sign up for [CMS ICD-10 Industry Email Updates](#) or follow them on [Twitter](#).
- Download the [Special Edition ICD-10 Newsletter](#).

Billing and Coding Instructions for BH and SUD Providers

The following tables list the appropriate codes to bill for services. (These lists reflect frequently billed codes, and are subject to change as mandated by OMH, OASAS and NYSDOH.)

Comprehensive Psychiatric Emergency Program (CPEP)

Note: Services must be billed with place of service (POS) 23, with the exception of service codes S4984 and H0037, which should be billed with POS 22.

REV	CPT	Code Description	Rate Code	Rate Code Description	Modifier
900	90791	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem-focused history; a problem-focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self-limited or minor.	4007	Brief Emergency Visit	HK, U5
900	90791	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are of low to moderate severity.	4008	Full Emergency Visit	HK
900	S9485	Crisis intervention mental health services, per diem. These are emergency services provided outside an emergency room setting.	4009	Full Emergency Visit	HK
900	H0037	Community psychiatric supportive treatment program, per diem. These are emergency services provided outside an emergency room setting to persons released from CPEP.	4009	Crisis Outreach Service Visit	HK

Assertive Community Treatment (ACT)

Billing Instructions

ACT services are reimbursed in the following way:

- ACT services are billed once monthly. When submitting claims, use the last day of the month in which the services are rendered as the date of services.

Each claim must be for a face-to-face contact (ACT team member and recipient).

Only one agency may bill when team members are from more than one agency. The billing provider reimburses other contributing agencies.

Bill ACT program services to Healthfirst using 837I:

- Use procedure code H0040
- Enter one date of service per line
- Enter place of service (POS) 21 if ACT services were provided to a recipient in an inpatient hospital and (POS) 53 for Community Mental Health Center

The following tables list the appropriate codes to bill for services:

REV	CPT	Code Description	Modifier	Modifier Description	Rate Code	Rate Code Description	Max Units
240 900 911	H0040	Assertive community treatment program, per diem	No Mod	Regular 68	4508	ACT 68/ Intensive full payment	6+
240 900 911	H0040	Assertive community treatment program, per diem	U5	Reduced Services	4509	Partial Intensive	2-5
240 900 911	H0040	Assertive community treatment program, per diem	U1U5	Inpatient/ Reduced	4511	Partial Intensive	2+

Intensive Psychiatric Rehabilitation Treatment (IPRT) Programs

REV	CPT	Code Description	Modifier	Modifier Description	Rate Code	Rate Code Description	Max Units
900 911	H2012	Behavioral health day treatment, per hour	HK, U1	Specialized MH Program for high-risk populations	4364	1 Hour	1
900 911	H2012	Behavioral health day treatment, per hour	HK, U2	Specialized MH Program for high-risk populations	4365	2 Hours	2
900 911	H2012	Behavioral health day treatment, per hour	HK, U3	Specialized MH Program for high-risk populations	4366	3 Hours	3
900 911	H2012	Behavioral health day treatment, per hour	HK, U4	Specialized MH Program for high-risk populations	4367	4 Hours	4
900 911	H2012	Behavioral health day treatment, per hour	HK, U5	Specialized MH Program for high-risk populations	4368	5 Hours	5

Partial Hospitalization

- Enter the type of bill (TOB) 13X Outpatient
- Enter the type of bill (TOB) 76X
Community Mental Health Center (CMHC)
- Use revenue code 912/0912 (Psychiatric/psychological svc
partial hosp less intensive)
- Use revenue code 913/0913 (Psychiatric/psychological svc
partial hosp intensive)
- Use procedure code H0035

*UA Modifier only to be used for preadmission

*HK Modifier is to differentiate claim from clinic

REV	CPT	Code Description	Modifier	Modifier Description	Rate Code	Rate Code Description	Max Units
912 913	H0035	Mental health partial hospitalization, treatment, less than 24 hours	U4	4 Hours billed	4349	4 Hours	4
912 913	H0035	Mental health partial hospitalization, treatment, less than 24 hours	U5	5 Hours billed	4350	5 Hours	5
912 913	H0035	Mental health partial hospitalization, treatment, less than 24 hours	U6	6 Hours billed	4351	6 Hours	6
912 913	H0035	Mental health partial hospitalization, treatment, less than 24 hours	U7	7 Hours billed	4352	7 Hours	7
912 913	H0035	Mental health partial hospitalization, treatment, less than 24 hours	U1 HR or HS	Family w/client or Family w/o Client	4353	Collateral 1 Hour	1
912 913	H0035	Mental health partial hospitalization, treatment, less than 24 hours	U2 HR or HS	Family w/client or Family w/o Client	4354	Collateral 2 Hours	2
912 913	H0035	Mental health partial hospitalization, treatment, less than 24 hours	U1 HR or HS or HQ	Family w/client or Family w/o Client or Group Setting	4355	GR Collateral 1 Hour	1
912 913	H0035	Mental health partial hospitalization, treatment, less than 24 hours	U2 HR or HS or HQ	Family w/client or Family w/o Client or Group Setting	4356	GR Collateral 2 Hours	2

Partial Hospitalization

REV	CPT	Code Description	Modifier	Modifier Description	Rate Code	Rate Code Description	Max Units
912 913	S9484	Crisis intervention mental health services, per hour	HK U1	1 Hour billed	4357	Crisis 1 Hour	1
912 913	S9484	Crisis intervention mental health services, per hour	HK U2	2 Hours billed	4358	Crisis 2 Hours	2
912 913	S9484	Crisis intervention mental health services, per hour	HK U3	3 Hours billed	4359	Crisis 3 Hours	3
912 913	S9484	Crisis intervention mental health services, per hour	HK U4	4 Hours billed	4360	Crisis 4 Hours	4
912 913	S9484	Crisis intervention mental health services, per hour	HK U5	5 Hours billed	4361	Crisis 5 Hours	5
912 913	S9484	Crisis intervention mental health services, per hour	HK U6	6 Hours billed	4362	Crisis 6 Hours	6
912 913	S9484	Crisis intervention mental health services, per hour	HK U7	7 Hours billed	4363	Crisis 7 Hours	7



Continuing Day Treatment (CDT)

REV	CPT	Code Description	Modifier	Modifier Description	Rate Code	Rate Code Description	Max Units
900 907 911	H2012	Behavioral health day treatment, per hour	U1U5	1–40 Hrs./ Reduced Service to indicate half a day	4310	Half day 1–40 Cumm Hrs.	2–3
900 907 911	H2012	Behavioral health day treatment, per hour	U2U5	41–64 Hrs./ Reduced Service to indicate half a day	4311	Half day 41–64 Cumm Hrs.	2–3
900 907 911	H2012	Behavioral health day treatment, per hour	U3U5	65+Hrs/ Reduced Service to indicate half a day	4312	Half day 65+ Cumm Hrs.	2–3
900 907 911	H2012	Behavioral health day treatment, per hour	U1	1–40 Hrs.	4316	Full day 1–40 Cumm Hrs.	4–5
900 907 911	H2012	Behavioral health day treatment, per hour	U2	41–64 Hrs.	4317	Full day 41–64 Cumm Hrs.	4–5
900 907 911	H2012	Behavioral health day treatment, per hour	U3	65+ Hrs.	4318	Full day 65+ Cumm Hrs.	4–5
900 907 911	H2012	Behavioral health day treatment, per hour	UK	Services provided on behalf of the client to someone other than the client (collateral relationship)	4325	Collateral	1–2
900 907 911	H2012	Behavioral health day treatment, per hour	UKHQ	Services provided on behalf of the client to someone other than the client (collateral relationship)/ Group setting	4331	Group Collateral	1–2
900 907 911	H2012	Behavioral health day treatment, per hour	U8	Crisis	4337	Crisis	1
900 907 911	H2012	Behavioral health day treatment, per hour	U9	Pre-Admission	4346	Pre-Admission	1

NYS OMH Licensed CRs

Note: Additional information required for this service.

CPT	Code Description	Modifier	Modifier Description	Rate Code	Rate Code Description	Max Units
H0044 H2018	Supported housing, per month Psychosocial rehab, per diem	HE	Mental health program	4369	Monthly Rehabilitative Fee	1 21+
H0044 H2018	Supported housing, per month Psychosocial rehab, per diem	HE U1	Mental health program First half of month (state defined)	4370	Semi-Monthly Rehab Fee- 1 st Half	1 11-20
H0044 H2018	Supported housing, per month Psychosocial rehab, per diem	HE U2	Mental health program Second half of month (state defined)	4371	Semi-Monthly Rehab Fee- 2 nd Half	1 11-20
H0044 H2018	Supported housing, per month Psychosocial rehab, per diem	HE HW	Mental health program state-funded (operated)	4389	State Op Adult Crs Full Month	1 21+
H0044 H2018	Supported housing, per month Psychosocial rehab, per diem	HE HW U1	Mental health program, state-funded (operated) First half of month (state defined)	4390	State Op Adult Crs 1 st Half Month	1 11-20
H0044 H2018	Supported housing, per month Psychosocial rehab, per diem	HE HW U2	Mental health program, state-funded (operated) Second half of month (state defined)	4391	State Op Adult Crs 2 nd Half Month	State Op Adult Crs 2 nd Half Month

Personalized Recovery Oriented Services (PROS)

REV	CPT	Code Description	Modifier	Modifier Description	Rate Code	Rate Code Description	Max Units
240 900 911	H0002	Behavioral health screening to determine eligibility for admission to treatment program	HE	Mental Health Program	4510	Pros-Pre-admission	2-3
240 900 911	H2019	Therapeutic behavioral services, per 15 minutes	U1	Level 1 (state-defined)	4520	Comprehensive downstate 2-12 Hrs.	2-3
240 900 911	H2019	Therapeutic behavioral services, per 15 minutes	U2	Level 2 (state-defined)	4521	Comprehensive downstate 13-27 Hrs.	2-3
240 900 911	H2019	Therapeutic behavioral services, per 15 minutes	U3	Level 3 (state-defined)	4522	Comprehensive downstate 28-43 Hrs.	4-5
240 900 911	H2019	Therapeutic behavioral services, per 15 minutes	U4	Level 4 (state-defined)	4523	Comprehensive downstate 44-60	4-5
240 900 911	H2019	Therapeutic behavioral services, per 15 minutes	U5	Level 5 (state-defined)	4524	Comprehensive Downstate 61+ Hrs.	4-5
240 900 911	T1015	Clinic visit/encounter, all-inclusive	HE	Mental Health Program	4525	Comprehensive Downstate Clinical Treatment	1-2
240 900 911	H2018	Psychosocial rehabilitation services, per diem	HE	Mental Health Program	4526	Comprehensive Downstate Intensive Rehab	1-2
240 900 911	H2025	Ongoing support to maintain employment, per 15 minutes	HE	Mental Health Program	4527	Comprehensive Downstate Ongoing Rehab & Support	1
240 900 911	H0002	Behavioral health screening, admission eligibility	UB, HE	BIP population patient (state-defined), Mental health program	4531	Pre-Admission-AH/NH/PC	1

Personalized Recovery Oriented Services (PROS)

REV	CPT	Code Description	Modifier	Modifier Description	Rate Code	Rate Code Description	Max Units
240 900 911	H2019	Therapeutic behavioral services, per 15 minutes	UB, U2	BIP population patient (state-defined), 2 or 3 units (state-defined)	4532	Enhanced Crs 2 Contact-AH/NH/PC	1
240 900 911	H2019	Therapeutic behavioral services, per 15 minutes	UB, U4	BIP population patient (state-defined), 4 or more units (state-defined)	4533	Enhanced Crs 4 Contact-AH/NH/PC	1
240 900 911	H2018	Psychosocial rehabilitation services, per diem	UB, HE	This code is used in place of 4526 for the BIP population. The billing requirements are the same as 4526, but include the UB modifier	4534	Intensive Rehabilitation-AH/NH/PC	1

Medical Doctors (MDs) and Nurse Practitioners (NPs) Rendering Psychiatric Services

Note: Only MDs are allowed to bill Office E&M code ranges of 99201–99205 and 99212–99215.

CPT	Code Description
Diagnostic Interview Procedures	
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
Psychotherapy	
90832	Psychotherapy, 30 min with patient and/or family member
90833	Psychotherapy, 30 min with patient and/or family member when performed with an E&M service (List separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 min with patient and/or family member
90836	Psychotherapy, 45 min with patient and/or family member when performed with an E&M service (List separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 min with patient and/or family member
90838	Psychotherapy, 60 min with patient and/or family member when performed with an E&M service (List separately in addition to the code for primary procedure)
90846	Family psychotherapy without the patient present
90847	Family psychotherapy, conjoint psychotherapy with the patient present
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
96101	Psychological testing
Interactive Complexity Add-On Code	
90785	Add-on code to be used in conjunction with codes for primary service: psychiatric diagnostic evaluation (90791); psychotherapy (90832, 90834, 90837); and group psychotherapy (90853)
Psychotherapy For Crisis	
90839	Psychotherapy for crisis, first 60 min
90840	Add-on for each additional 30 min of psychotherapy for crisis, used in conjunction with code 90839
Pharmacologic Management Add-On Code	
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services; used only as add-on to primary psychotherapy code (90832, 90834, 90837)

Non-MDs Rendering Psychotherapy Services

CPT	Code Description
Diagnostic Interview Procedures	
90791	Psychiatric diagnostic evaluation
Psychotherapy	
90832	Psychotherapy, 30 min with patient and/or family member
90834	Psychotherapy, 45 min with patient and/or family member
90837	Psychotherapy, 60 min with patient and/or family member
90845	Psychoanalysis
90846	Family psychotherapy without the patient present
90847	Family psychotherapy, conjoint psychotherapy with the patient present
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
Interactive Complexity Add-On Code	
90785	Add-on code to be used in conjunction with codes for primary service: psychiatric diagnostic evaluation (90791); psychotherapy (90832, 90834, 90837); and group psychotherapy (90853)
Psychotherapy For Crisis	
90839	Psychotherapy for crisis, first 60 min
90840	Add-on for each additional 30 min of psychotherapy for crisis, used in conjunction with code 90839



Billing and Coding Instructions for BH-HCBS Providers

When submitting claims for approved waiver program services:

- Provider must enter a diagnosis code when submitting claims for all waiver services
- Providers are required to use the most current, most specific diagnosis code when submitting their claims
- Use the information submitted on your authorization when submitting claims for reimbursement through the waiver program
- Use the appropriate modifier when appropriate

Healthfirst Personal Wellness Plan Behavioral Health Home and Community Based Services (BH-HCBS)

Psychosocial Rehabilitation (PSR)	Empowerment Services—Peer Support
Community Psychiatric Support and Treatment (CPST)	Pre-vocational Services
Habilitation/Residential Support Services	Transitional Employment
Family Support and Training (FST)	Intensive Supported Employment (ISE)
Short-term Crisis Respite	Ongoing Supported Employment
Intensive Crisis Respite	Education Support Services

Important Points For BH-HCBS Providers

- BH-HCBS waiver claims are billed on a **UB-04 claim form**.
- If a unit of service equals 15 minutes, a minimum of eight minutes must be provided to bill for one unit.
- Activities requiring less than eight minutes may be accrued to the end of that date of service.
- At the end of the day, partial units may be rounded as follows: units totaling more than eight minutes may be rounded up and billed as one unit.
- Partial units totaling less than eight minutes may not be billed.

Service Combinations

Only certain combinations of HCBS and State Plan services are allowed by Medicaid within an individual's current treatment plan. The grid below shows the allowable service combinations.

HCBS Plan Services	OMH Clinic/ OLP	OASAS Clinic	OASAS Opioid Treatment Program	OMH ACT	OMH PROS	OMH IPRT/CDT	OMH Partial Hospital	OASAS Outpatient Rehab
PSR	Yes	Yes	Yes	No	No	No	Yes	No
CPST	No	No	No	No	No	No	Yes	No
Habilitation	Yes	Yes	Yes	No	No	No	Yes	No
Family Support and Training	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Education Support Services	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Peer Support Services	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Employment Services	Yes	Yes	Yes	No	No	Yes	Yes	Yes

Please Note: New York State and Healthfirst will monitor and periodically review claim and encounter data to determine if inappropriate BH-HCBS and State Plan service combinations were provided/allowed.

Behavioral Health Home and Community Based Services (BH-HCBS)

REV	Rate Code	Rate Code Description	CPT	CPT Code Description	Modifiers	Unit Measure	Unit Limits	Edits
900 911	7778	BH-HCBS Eligibility Brief Assessment (by Health Home or arm's length entity under contract with the Healthfirst PWP)	H0002	Behavioral health screening to determine eligibility for admission to HCBS treatment program	HH	None, code 1 unit	1	Three per year
900 911	7784	Psychosocial Rehabilitation– Per 15 Min (Individual on-site "one on one")	H2017	Psychosocial rehabilitation services; per 15 min	U1	Per 15 min	8	Cannot be billed on the same day as group
900 911	7785	Psychosocial Rehabilitation– Per 15 Min (individual off-site "one on one")	H2017	Psychosocial rehabilitation services; per 15 min	U1	Per 15 min	8	Cannot be billed on the same day as group
900 911	7786	Psychosocial Rehabilitation– Per 15 Min (group of 2 or 3)	H2017	Psychosocial rehabilitation services; per 15 min	UN or UP	Per 15 min	4	Not billable with mileage based transportation
900 911	7787	Psychosocial Rehabilitation– Per 15 Min (group of 4 or 5)	H2017	Psychosocial rehabilitation services; per 15 min	UN or UP	Per 15 min	4	Not billable with mileage based transportation
900 911	7788	Psychosocial Rehabilitation– Per 15 Min (group of 6-10)	H2017	Psychosocial rehabilitation services; per 15 min	UQ or UR	Per 15 min	4	Cannot be billed on the same day as per diem PSR service; not billable with mileage based transportation
900 911	7789	Psychosocial Rehabilitation– Per Diem (individual– "one on one")	H2017	Psychosocial Rehabilitation; per diem	US	Per Diem	1	

Behavioral Health Home and Community Based Services (BH-HCBS)

REV	Rate Code	Rate Code Description	CPT	CPT Code Description	Modifiers	Unit Measure	Unit Limits	Edits
900 911	7790	BH-HCBS CPST (physician)	H0036	Community Psychiatric Supportive Treatment, face-to-face; per 15 min	AF	Per 15 min	6	
900 911	7791	Community Psychiatric Support and Treatment (NP, psychologist)	H0036	Community Psychiatric Supportive Treatment, face-to-face; per 15 min	SA or AH	Per 15 min	6	
900 911	7792	Community Psychiatric Support and Treatment (RN, Licensed Social Worker)	H0036	Community Psychiatric Supportive Treatment, face-to-face; per 15 min	TD or AJ	Per 15 min	6	
900 911	7793	Community Psychiatric Support and Treatment (all other allowable professions)	H0036	Community Psychiatric Supportive Treatment, face-to-face; per 15 min		Per 15 min	6	
900 911	7794	BH-HCBS Peer Supports—by credentialed staff	H0038	Self Help/Peer Services; per 15 min	HE or HF	Per 15 min	16	
900 911	7795	BH-HCBS Residential Supports (Habilitation)	T2017	Habilitation, residential—waiver, 15 min		Per 15 min	12	
900 911	7796	Short-term Crisis Respite (dedicated facil)	H0045	Respite Care Services, not in the home; per diem	HK, U5	Per 15 diem	1	Limit of 21 units (days) in 12 months per calendar year
900 911	7798	Intensive Crisis Respite	H0045	Respite Care Services, not in the home; per diem	HK	Per diem	1	Limit of 21 units (days) in 12 months per calendar year
900 911	7799	BH-HCBS Family Support/ Training (individual)	H2014	Skills training and development; per 15 min	HR or HS	Per 15 min	12	

Behavioral Health Home and Community Based Services (BH-HCBS)

REV	Rate Code	Rate Code Description	CPT	CPT Code Description	Modifiers	Unit Measure	Unit Limits	Edits
900 911	7800	BH-HCBS Family Support/ Training (group of 2 or 3)	H2014	Skills training and development; per 15 min	HR or HS, UN or UP	Per 15 min	6	
900 911	7801	BH-HCBS Pre-vocational	T2015	Habilitation prevocational, waiver; per hour		Per hour	2	Only one employment service per day
900 911	7802	BH-HCBS Transitional Employment	T2019	Habilitation, supported employment, waiver; per 15 min		Per 15 min	12	Only one employment service per day
900 911	7803	Intensive Supported Employment	H2023	Supported Employment	TG	Per 15 min	12	Only one employment service per day
900 911	7804	Ongoing Supported Employment	H2025	Ongoing support to maintain employment; per 15 min		Per 15 min	12	Only one employment service per day
900 911	7805	Education Support Services	T2013	Habilitation educational, waiver		Per hour	2	

Children's Family Treatment and Support Services (CFTSS) and Behavioral Health Home and Community Based Services (BH-HCBS)

Children's SPA Services*

Other Licensed Practitioner	January 1, 2019
Psychosocial Rehabilitation	January 1, 2019
Community Psychiatric Treatment and Supports (CPST)	January 1, 2019
Family Peer Support Services (FPSS)	July 1, 2019
Youth Peer Support and Training	January 1, 2020
Crisis Intervention	January 1, 2020

*On January 1, 2019, children transitioning to 1115 who were receiving crisis intervention, family peer supports, and youth peer supports and training under a 1915c waiver continued receiving these services under 1115 authority; this ensured no break in service for these children.

Please Note: New York State and Healthfirst will monitor and periodically review claim and encounter data to determine if inappropriate BH-HCBS and State Plan service combinations were provided/allowed.

Revenue Code 900 or 911

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
OLP Licensed Evaluation	7900	90791	EP	15 Minutes	36/year
OLP Counseling – Individual	7901	H0004	EP	15 Minutes	4
OLP Counseling – Family with Client	7901	H0004	HR	15 Minutes	4
OLP Counseling – Family without Client	7901	H0004	HS	15 Minutes	4
OLP Crisis (Offsite, In-person only)	7902	H2011	EP, ET	15 Minutes	8
OLP Crisis Triage (By Phone)	7903	H2011	EP, GT	15 Minutes	2
OLP Crisis Complex Care (Follow up)	7904	90882	EP, TS	5 Minutes	4
OLP Counseling – Group	7905	H0004	HQ, EP	15 Minutes	4
Offsite – OLP Individual	7920	90791	EP, SC	15 Minutes	36/year
Offsite – OLP Individual	7920	H0004	SC	15 Minutes	4
Offsite – OLP Family with client	7920	H0004	HR SC	15 Minutes	4
Offsite – OLP Family without client	7920	H0004	HS SC	15 Minutes	4
Offsite – OLP Counseling Group	7927	H0004	EP, HQ, SC	15 Minutes	4
CPST Service Professional	7911	H0036	EP	15 Minutes	6
CPST Service Professional – Group	7912	H0036	EP, HQ	15 Minutes	4
Offsite – CPST Individual	7921	H0036	EP, SC	15 Minutes	6
Offsite – CPST Group	7928	H0036	EP, HQ, SC	15 Minutes	4
PSR Service Professional	7913	H2017	EP	15 Minutes	8
PSR Service Professional – Group	7914	H2017	EP, HQ	15 Minutes	4
Offsite – PSR Individual	7922	H2017	EP, SC	15 Minutes	8
Offsite – PSR Group	7929	H2017	EP, HQ, SC	15 Minutes	4
Family Peer Support Service Professional	7915	H0038	EP, UK	15 Minutes	8
Family Peer Support Service Professional – Group	7916	H0038	EP, UK, HQ	15 Minutes	6
Offsite – FPSS – Individual	7923	H0038	EP, UK, SC	15 Minutes	8
Offsite – FPSS – Group	7930	H0038	EP, HQ, SC, UK	15 Minutes	6
Youth Peer Support Service Professional	7917	H0038	EP	15 Minutes	8
Youth Peer Support Service Professional – Group	7918	H0038	EP, HQ	15 Minutes	6
Offsite – YPSS – Individual	7923	H0038	EP, SC	15 Minutes	8
Offsite – YPSS – Group	7930	H0038	EP, HQ, SC	15 Minutes	6
CI 1 Licensed Practitioner	7906	H2011	EP, HO	15 Minutes	6

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
CI 1 Licensed Practitioner & 1 Peer Support	7907	H2011	EP, HT	15 Minutes	6
CI 2 Licensed Practitioners	7908	H2011	EP	15 Minutes	6
CI 90-180 min & 2 clinicians, 1 licensed	7909	S9484	EP	Per Diem	1
CI Per diem 3 hrs., 2 clinicians, 1 licensed	7910	S9485	EP	Per Diem	1

Children's HCBS

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Caregiver Family Supports and Services - Individual	8003	H2014	UK HA	15 minutes	12
Caregiver Family Supports and Services - Group of 2	8004	H2014	HA UK UN	15 minutes	12
Caregiver Family Supports and Services - Group of 3	8005	H2014	HA UK UP	15 minutes	12
Prevocational Services - Individual	8006	T2015	HA	Per Hour	2
Prevocational Services - Group of 2	8007	T2015	HA UN	Per Hour	2
Prevocational Services - Group of 3	8008	T2015	HA UP	Per Hour	2
Community Advocacy and Support - Individual	8009	H2015	HA	15 minutes	12
Community Advocacy and Support - Group of 2	8010	H2015	HA UN	15 minutes	12
Community Advocacy and Support - Group of 3	8011	H2015	HA UP	15 minutes	12
Supported Employment	8015	H2023	HA	15 minutes	12
Palliative Care Pain and Symptom Management	8016	99347	TJ	15 minutes	No limit, as required by participant's physician
Palliative Care Bereavement Services	8017	90832	TJ	30 minutes	Limited to the lesser of 10 units per month or 120 units per calendar year
Palliative Care Massage Therapy	8018	97124	TJ	15 minutes	72 units/year
Palliative Care Expressive Therapy	8019	96152	TJ	15 minutes	48 units/year
Planned Respite - Individual (under 4 hours)	8023	S5150	HA	15 minutes	16
Planned Respite - Individual per diem (4+ hours)	8024	S5151	HA	Per Diem	1
Planned Respite - Group (under 4 hours)	8027	S5150	HA HQ	15 minutes	16
Crisis Respite - under 4 hours	8028	S5150	HA ET	15 minutes	16
Crisis Respite - more than 4 hours, less than 12 hours	8029	S5151	HA ET	Per Diem	1
Crisis Respite - Individual (12+ hours, less than 24 hours)	8030	S5151	HA ET HK	Per Diem	1
Community HCBS Habilitation	8012	H2014	HA	15 minutes	24
Community HCBS Habilitation - Group of 2	8013	H2014	HA UN	15 minutes	24

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Community HCBS Habilitation - Group of 3 or more	8014	H2014	HA UP	15 minutes	24
Day HCBS Habilitation	7933	T2020	HA	15 minutes	24
Day HCBS Habilitation - Group of 2	7934	T2020	HA UN	15 minutes	24
Day HCBS Habilitation - Group of 3 or more	7935	T2020	HA UP	15 minutes	24
Environmental Modifications	8032	S5165	HA	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Environmental Modifications	8034	S5165	HA V1	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Environmental Modifications	8035	S5165	HA V2	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Environmental Modifications	8036	S5165	HA V3	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Vehicle Modifications	8041	T2039	HA	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Vehicle Modifications	8042	T2039	HA V1	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Vehicle Modifications	8043	T2039	HA V2	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Vehicle Modifications	8044	T2039	HA V3	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Adaptive and Assistive Equipment	8037	T2028	HA	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Adaptive and Assistive Equipment	8038	T2028	HA V1	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Adaptive and Assistive Equipment	8039	T2028	HA V2	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Adaptive and Assistive Equipment	8040	T2028	HA V3	Per Unit	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary

Claims for the above services must be submitted using revenue code 900 or 911.

Place of Service (POS) Definitions

POS Code	POS Name	POS Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Freestanding Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Freestanding Facility	A facility or location, owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location, owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/ Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either federal, state, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hrs. a day/7 days a wk., with the capacity to deliver or arrange for services including some healthcare and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place to place and that is equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Place of Service (POS) Definitions—(Cont'd)

POS Code	POS Name	POS Description
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical/nonsurgical), and rehabilitation services by or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room—Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birth Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborns.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but that does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance—Land	A land vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
42	Ambulance—Air or Water	An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

Place of Service (POS) Definitions—(Cont'd)

POS Code	POS Name	POS Description
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/ Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or by using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural, medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

Appendix A— Services that Require Authorization

BH and SUD Services Requiring Authorization for PWP Members

This table outlines services that will require authorization from Behavioral Health and SUD providers:

Benefit Name

Assertive Community Treatment (ACT)

Inpatient Chemical Dependence Rehabilitation and Treatment Services

Inpatient Medically Managed Detoxification (Inpatient Hospital Detox)

Inpatient Mental Health Services

Intensive Outpatient Mental Health (OTP OMH)
--

Medically Supervised Outpatient Withdrawal (Detox) (MSOW)

Partial Hospitalization

Personalized Recovery Oriented Services (PROS)
--

***Disclaimer:** This list is not limited and may be subject to change.

CFTSS that Require Concurrent Review for Medicaid Members Under Age 21

Benefit Name

Psychosocial Rehabilitation (PSR)

Community Psychiatric Support and Treatment (CPST)
--

***Disclaimer:** This list is not limited and may be subject to change.

BH-HCBS Requiring Authorization for PWP Members

This table outlines services that require authorization from BH-HCBS providers:

Benefit Name
Psychosocial Rehabilitation (PSR)
Community Psychiatric Support and Treatment (CPST)
Habilitation/Residential Support Services
Family Support and Training (FST)
Education Support Services
Empowerment Services – Peer Support
Prevocational Services
Transitional Employment
Intensive Supported Employment (ISE)
Ongoing Supported Employment
Short-term Crisis Respite – <i>(authorization required after 72 hrs)</i>
Intensive Crisis Respite – <i>(authorization required after 72 hrs)</i>

***Disclaimer:** This list is not limited and may be subject to change.

Please Note: Non-emergency transportation services and non-medical transportation services in New York City are being handled by New York State's contracted vendor, Medical Answering Services. These same services in Long Island are being handled by New York State's contracted vendor, LogistiCare. Non-medical transportation is covered only for Personal Wellness Plan members.

UB-04 Field Requirements

Field No.	Field Description	Required
1	Billing Provider Name	Yes
	Billing Street Address	Yes
	Billing Provider City, State, Zip	Yes
	Billing Provider Telephone, Fax, Country Code	Yes
2	Billing Provider's Designated Pay-to Name	No
	Billing Provider's Designated Pay-to Address	No
	Billing Provider's Designated Pay-to City, State	No
	Billing Provider's Designated Pay-to ID	No
3a	Patient Control Number	Yes
3b	Medical/Health Record Number	No
4	Type of Bill	Yes
5	Federal Tax Number	Yes
6	Statement Covers Period – From/Through	Yes
7	UNLABELED	No
8a	Patient ID	Yes
8b	Patient Name	Yes
9a	Patient Address – Street	No
9b	Patient Address – City	No
9c	Patient Address – State	No
9d	Patient Address – ZIP	No
9e	Patient Address – Country Code	No
10	Patient Birthdate	Yes
11	Patient Sex (Gender)	Yes
12	Admission Date/Start of Care Date	Yes
13	Admission Hour	No
14	Priority (Type) of Admission or Visit	Yes
15	Point of Origin for Admission or Visit (SRC)	No
16	Discharge Hour	No
17	Patient Discharge Status	Yes
18–28	Condition Code	Yes
29	Accident State	No
30	N/A UNLABELED	No
31a–34b	Occurrence Code/Date	Yes
35a–36b	Occurrence Span Code/From/Through	No
37	N/A UNLABELED	No
38	Responsible Party Name/Address	No

UB-04 Field Requirements—(Cont'd)

Field No.	Field Description	Required
39–41	Value Code	Yes
42	Revenue Codes	Yes
43	Revenue Code Description/IDE Number/Medicaid Drug Rebate	No
44	HCPCS/Accommodation Rates/HIPPS Rate Codes	Yes
45	Service Dates	Yes
46	Service Units	Yes
47	Total Charges	Yes
48	Non-Covered Charges	No
49	UNLABELED	Yes
50a	Payer Identification – Primary	No
50b	Payer Identification – Secondary	No
50c	Payer Identification – Tertiary	No
51a–51c	Health Plan <i>Identification Number</i>	No
52a	Release of Information – Primary	No
52b	Release of Information – Secondary	No
52c	Release of Information – Tertiary	No
53a	Assignment of Benefits – Primary	No
53b	Assignment of Benefits – Secondary	No
53c	Assignment of Benefits – Tertiary	No
54a	Prior Payments – Primary	No
54b	Prior Payments – Secondary	No
54c	Prior Payments – Tertiary	No
55a	Estimated Amount Due – Primary	No
55b	Estimated Amount Due – Secondary	No
55c	Estimated Amount Due – Tertiary	No
56	NPI	Yes
57a–57b	Other Provider ID	No
57c	N/A B94Other Provider ID	No
58a	Insured's Name – Primary	No
58b	Insured's Name – Secondary	No
58c	Insured's Name – Tertiary	No
59a	Patient's Relationship – Primary	No
59b	Patient's Relationship – Secondary	No
59c	Patient's Relationship – Tertiary	No
60a	Insured's Unique ID – Primary	Yes
60b	Insured's Unique ID – Secondary	No
60c	Insured's Unique ID – Tertiary	No
61a	Insurance Group Name – Primary	No
61b	Insurance Group Name – Secondary	No
61c	Insurance Group Name – Tertiary	No

UB-04 Field Requirements–(Cont'd)

Field No.	Field Description	Required
62a	Insurance Group Number – Primary	No
62b	Insurance Group Number – Secondary	No
62c	Insurance Group Number – Tertiary	No
63a	Treatment Authorization Code – Primary	No
63b	Treatment Authorization Code – Secondary	No
63c	Treatment Authorization Code – Tertiary	No
64a–64c	Document Control Number (DCN)	No
65a	Employer Name (of the insured) – Primary	No
65b	Employer Name (of the insured) – Secondary	No
65c	Employer Name (of the insured) – Tertiary	No
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	Yes
67	Principal Diagnosis Code and Present on Admission (POA) Indicator	Yes
67a–67q	Other Diagnosis and POA Indicator	No
68	N/A UNLABELED	
69	Admitting Diagnosis Code	Yes
70a–70c	Patient Reason for Visit Code	No
71	Prospective Payment System (PPS) Code	No
72a–72c	External Cause of Injury (ECI) Code and POA Indicator	No
73	N/A UNLABELED	No
74	Principal Procedure Code/Date	No
74a–74e	Other procedure code/date	No
75	N/A UNLABELED	No
76 Line 1	Attending Provider NPI and Qual <i>For unlicensed practitioners without an NPI, the OMH (02249154) or OASAS (02249145) unlicensed practitioner ID may be used.</i>	Yes
76 Line 2	Attending Provider – Last Name/First Name	Yes
77 Line 1	Operating Physician NPI and Qual	Yes
77 Line 2	Operating Physician – Last Name/First Name	Yes
78 Line 1	Other Provider NPI and Qual	No
78 Line 2	Other Provider Last Name/First Name	No
79 Line 1	Other Provider NPI and Qual	No
79 Line 2	Other Provider – Last Name/First Name	No
80 Lines 1–4	Remarks	No
81	Code-Code-QUALIFIER/CODE/VALUE	No

Appendix C– PWP Quick Reference Guide

Important Contact Information

PROVIDER SERVICES	MEMBER SERVICES	UTILIZATION MANAGEMENT
P.O. Box 5168 New York, NY 10274-5168 1-888-801-1660 Fax: 1-646-313-4634 Monday to Friday 8:30am–5:30pm hfprovsrvs@healthfirst.org	P.O. Box 5165 New York, NY 10274-5165 Personal Wellness Plan: 1-855-659-5971 24 hours a day, 7 days a week (English, Spanish, Chinese) Medicaid Fee-for-Service Transportation: (all NYC boroughs) – Medical Answering Services, 1-844-666-6270 , 24 hours a day, 7 days a week (Long Island) – LogistiCare, 1-844-678-1103 Monday to Friday, 7am–6pm	P.O. Box 5166 New York, NY 10274-5166 1-888-394-4327 Fax: 1-646-313-4603 TTY 1-888-542-3821 24 hours a day, 7 days a week Providers requesting BH-HCBS, ACT, or PROS can fax authorization requests to 1-646-313-4612

Online Tools and Resources: healthfirst.org/providers

Access the secure provider portal to:

- Verify member eligibility
- Review claim status
- Search for providers
- Check authorization status and review details
- Update demographic information
- Submit Review and Reconsideration requests and corrected claims

Access provider resources and information for:

- Provider Alerts: healthfirst.org/alerts
- Provider Manual: HFProviderManual.org
- Provider Directory: HFDocFinder.org
- Provider Forms: healthfirst.org/providerforms
- Provider Formulary: healthfirst.org/formulary
- Provider Newsletters: HFNYSource.org
- Submit Your Email Address: HFDocEmails.org
- New Providers: HFNewProviders.org

Access and Appointment Availability Requirements

- **Emergency care:** Immediately upon presentation
- After ER or hospital discharge, mental health or SUD follow-up visits: Within five days of discharge
- **Urgent medical and behavioral healthcare:** Within 24 hours
- Non-urgent visit for mental health or substance use disorder (SUD): Within two weeks
- **After hours:** Behavioral Health Service providers must provide on-call coverage for their respective practices 24 hours a day, 7 days a week and have a published after-hours telephone number (voicemail alone after hours is not acceptable)

Transportation

Emergency: If emergency transportation is needed, providers should call 911 to assist members with the emergency. These services are covered by Medicaid Fee-for-Service.

Non-Emergency: Routine transportation for Personal Wellness Plan (PWP) members within NYC's five boroughs is covered by the NYS transportation vendor Medical Answering Services (MAS). Providers should call MAS at **1-844-666-6270** to schedule transportation for these members.

Routine transportation for PWP members in Long Island (Nassau and Suffolk counties) is covered by NYS transportation vendor LogistiCare. Providers should call LogistiCare at **1-844-687-1103** to schedule transportation for these members.

Requests for non-medical transportation for Behavioral Health Home and Community Based Services (BH-HCBS) must be sent directly to a Healthfirst Care Manager. The Care Management team can be reached at **1-866-237-0997**. After the Healthfirst Care Manager approves the initial request, members are instructed to call the NYS transportation vendor to arrange future trips as follows: members within NYC's five boroughs should call MAS at **1-844-666-6270**, while members within Long Island counties should call LogistiCare at **1-844-678-1103**.

Care Management

All Personal Wellness Plan members are eligible for Health Home Care Management services, which provide community-based care coordination and recovery support. For members who choose not to receive Health Home services, Healthfirst will connect them to our Integrated Care Management Team to assist member in management of complex general medical and behavioral health conditions as well as social conditions.

For additional information or to refer a member for Health Home services or Healthfirst Care Management services, please contact Personal Wellness Plan Member Services at **1-855-659-5971** or the Healthfirst Care Coordination Unit at **1-800-404-8778**.

Discharge Planning

For quick assistance in facilitating discharge planning for a Personal Wellness Plan member, please call Healthfirst Utilization at **1-888-394-4327**.

Compliance

Anonymously report compliance concerns and/or suspected fraud, waste, and abuse that involves Healthfirst at **1-877-879-9137** or at hfcompliance.ethicspoint.com.

Ancillary Authorizations

- **Radiology** – eviCore: **1-877-773-6964**
- **Dental** – DentaQuest: **1-800-508-2047**
- **Routine Vision/Glasses** – Davis Vision: **1-800-753-3311**
- **Chiropractic Services** – ASH: **1-800-972-4226**
- **PT, OT, ST Services** – OrthoNet: **1-844-641-5629**
- **Pain Management/Spinal Surgery/Foot Surgery** – OrthoNet: **1-844-504-8091**
- **Cataract/Cosmetic Eye Surgery** – Superior Vision: **1-888-273-2121**
- **Pharmacy** – CVS Caremark
 - Personal Wellness Plan: **1-877-433-7643**
- **Specialty Pharmacy** – CVS Caremark: **1-866-814-5506**

Notification Requirements

- All Emergent Admissions:** Called in no later than one business day after admission
Newborns: Next business day following birth
Dialysis Notification Preferred: Authorization not required for in- or out-of-network

Preauthorization Guidelines

For authorization requirements on the Behavioral Health Carve-In, please review the authorization grid dated 01.05.16 on the Healthfirst website at healthfirst.org/providers/claims-billing.

Providers can obtain authorization by calling or faxing in a request to the Utilization Management numbers listed on the first page of this guide.

Outpatient

Authorization is **not** required for routine in-network outpatient behavioral health services except as indicated below.

Authorization is required on the following outpatient services:

- Mental Health (MH) Services:
 - Partial Hospital Programs (PHP)
 - Intensive Outpatient Programs (Mental Health Service IOP)
- Assertive Community Treatment (ACT)
- Personalized Recovery-Oriented Services (PROS)
- Ambulatory Detoxification
- Electroconvulsive Therapy (ECT)
- Neuropsychological Testing
- Psychological Testing
- Adult BH-HCBS, (Authorization is required for Crisis Respite with 72 hours)

Inpatient

Authorization is required for the following inpatient services. These will also be subject to retrospective and concurrent reviews in accordance with policies and procedures:

- Mental Health (MH) Services:
 - Inpatient, Psychiatric Admissions
- Substance Use Disorder (SUD) Treatment:
 - Inpatient Detoxification
 - Substance Use Rehabilitation

The following information must be supplied for authorization requests:

Outpatient

- Member's name and Healthfirst ID number
- PCP's name (if not the attending/requesting provider)
- Procedure(s) and CPT-4 Code(s) and procedure date(s)
- Attending/requesting provider's name, telephone number, and fax number
- Diagnosis and ICD-10 Code
- Services requested and proposed treatment plan

Inpatient

- All items on the left
- Hospital/facility Name
- Expected date of service
- Expected length of stay

Claims Guidelines

Mental Health, Substance Use Disorder (SUD) facilities, and outpatient clinic service claims must be submitted to Healthfirst electronically, using the 837(I), or by institutional paper claims, using the UB-04 claim form and the appropriate **rate codes**.

Claims Submissions: Claims must be submitted **within 180 days** of the date of service and should be done so either electronically or mailed as a hard copy to the address shown for the Claims department.

Electronic claim submissions must include the **National Provider Identifier (NPI)**, the Healthfirst **member ID number**, and the Healthfirst **Payer ID Number 80141**.

Paper claim submissions must include the **NPI**, and mailed to the following address:

Healthfirst Claims Department, P.O. Box 958438, Lake Mary, FL 32795-8438

Healthfirst provides a two (2)-level process for providers to appeal a claim denial or payment that the provider believes was incorrect or inaccurate.

First-Level Appeal Requests:

Reviews and Reconsiderations – Requests must be made in writing and, with supporting documentation, submitted within **90 calendar days** from the paid date on the Explanation of Payment (EOP).

Corrected Claims – Corrected claims must be marked "**Corrected**" and should be submitted within **180 days** of the date of service. All Corrected claims must include the original Healthfirst claim number being corrected. For electronic corrected claims submission, the claim frequency type code must be a 7.

These requests are accepted electronically through the secure Healthfirst Provider Portal at healthfirst.org, or may be mailed to:

Healthfirst Correspondence Department, P.O. Box 958438, Lake Mary, FL 32795-8438

Second-Level Appeal Requests:

Provider Claims Appeals – Providers may appeal the outcome of a Review and Reconsideration in writing, with supporting documentation, within **60 calendar days** from the date listed on the reconsideration letter. Appeals should be mailed to:

Healthfirst Provider Claim Appeals, P.O. Box 958431, Lake Mary, FL 32795-8431

All questions concerning requests should be directed to Provider Services at **1-888-801-1660**.

For further details on claims and request submissions, refer to the Healthfirst Provider Manual at HFProviderManual.org.

ICD-10

ICD-10 coding was implemented industrywide on October 1, 2015, replacing ICD-9 coding. All claims submitted with DOS after October 1, 2015 must include only ICD-10 codes. Claims submitted with combined ICD-9 and ICD-10 coding, and claims submitted without the appropriate code versions, will result in denials. More information on ICD-10 can be found online at www.cms.gov/ICD10 or www.healthfirst.org/ICD10.

