New York Children's Health and Behavioral Health Transition:
Children's Billing – Children and Family Treatment and Support Services (CFTSS) Billing and UM Office Hour Training
Frequently Asked Questions (FAQs)

Below is an FAQ concerning the Billing/Utilization Management Office Hour Webinar for the Children and Family Treatment and Support Services that are going live January 1, 2019: Other Licensed Practitioner (OLP), Psychosocial Rehabilitation (PSR), and Community Psychiatric Supports and Treatment (CPST).

As of January 2019

#	Topic	Question	State Response
1	Authorization	There is a minimum of 30 visits that must be authorized when MMCPs determine Medical Necessity Criteria for CFTS service requests. Does this 30 visit minimum occur at each subsequent concurrent review?	It is not required that 30 visits are authorized at each subsequent concurrent review beyond the first concurrent review authorization. Please refer to specific MMCP guidance about authorization at: https://ctacny.org/sites/default/files/UM%20Authorization%20Grid%203%20CFTSS%20jan%2015.pdf
2	Claims	Is there a deadline for claims testing?	MMCPs were required to open claims testing no later than December 1st 2018 and leave systems open for testing throughout the children's transition. There is no deadline, but it should be completed before a provider bills for services.

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3	Claims	If IT infrastructure is not fully in place for billing on Jan 1, can claims be backdated for a period of time?	Claims should be submitted with the accurate date of service, and providers have a minimum of 90 days to adhere to timely filing guidelines. Providers can submit paper claims if needed to ensure meets their contracted timely filing guidelines.
4	NPI/Enrollment	Can non-licensed providers for CFTSS and HCBS, that do not have a NPI, use the unlicensed provider number?	Yes. Non-licensed providers for CFTSS and HCBS that do not have a NPI can use the OMH unlicensed provider number 02249154 or the OASAS unlicensed provider number 02249145 More information on filling out clean claims can be found at www.billing.ctacny.org
5	NPI/Enrollment	If an agency is already an enrolled Medicaid provider, do they need to enroll specifically with Medicaid for the CFTS services?	Designated provider agencies must be enrolled as Medicaid providers. If the agency already has an MMIS number (Medicaid number), they do not need to re-enroll. Information about enrolling in Medicaid is available at here.
6	Notification	Is there a standard form for notifying MMCP of services to be provided to children? Should providers anticipate some acknowledgement by the MMCPs that they received the notification? If	There is no standard form for notifying plans prior to service delivery. Notification method/process depends on the MMCP. MCTAC has created a grid with more details about plan notification and authorization processes. This can be

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		no form, what does this notification look like?	viewed https://ctacny.org/sites/default/files/UM%20Authorization%20Grid%203%20CFTSS%20jan%2015.pdf
7	Off-site	What are the specifics about billing for mileage for an off-site visit? If PSR and CPST are provided in the same day can they both bill mileage for that client or is it only one of the services that can bill mileage per day?	There are set off-site rates, not a mileage reimbursement. Providers can only bill for one off-site if two different services were provided during the same trip.
8	Rate Codes	Please confirm that Crisis Complex Care (Follow Up) (rate code 7904) is 5 minutes as noted in billing manual and only allowed 4 units per day.	That is correct.
9	Rate Codes	Is there a rate code for OLP Complex Care off-site?	Complex Care is provided by telephone, so there is no differentiation needed for offsite vs. on site.

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10	Service Description	What is the difference between OLP services and therapeutic services through the Article 31 clinic? How do we distinguish when each is appropriate/when to bill for which?	The new OLP services are intended for children who have not or are not well suited for clinic based treatment, and would be better served in their home or community. OLP services only include assessment, treatment planning, psychotherapy and some crisis interventions. OLP can only be billed for children admitted to the service. Clinics can offer a full array of clinical treatment interventions, including but not limited to medication management and psychiatric evaluation. Clinic services are to be billed for any child enrolled in clinic.
11	Waiver Transition	For an HCBS Waiver recipient to receive CFTS services, they just need a recommendation by an LPHA, not an additional assessment, correct?	The LPHA should be a treating practitioner to be able verify medical necessity. If the LPHA is not treating them actively, they may need to do an assessment in order to determine medical necessity and write a recommendation. For additional detailed guidance for current 1915c Wavier providers on this issue, please go to: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/cftss_prep_billing.pdf
12	Waiver Transition	Who is responsible for obtaining the CFTSS recommendation for the waiver services cross-walking to CFTSS, the downstream waiver service provider or the HCI/ICC	For children who are currently enrolled in waiver, in most cases the HCI/ICC/care manager is responsible for securing a recommendation for CFTSS. Any HCBS provider working with an HCI/ICC should coordinate

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		(who will now be Health Home CMs)?	how recommendations will be secured for CFTSS to avoid duplication of effort.
13	Waiver Transition	To clarify, an LPHA must complete a recommendation for all enrolled HCBS clients by 1/18/19, yes?	This date has changed to 1/31/19.
14	Waiver Transition	If we cannot get an LPHA to complete the recommendation by 1/18/19, do we need to terminate services for HCBS clients currently receiving IIH/Skill Building?	This date has changed to 1/31/19. Please refer to the following guidance document for more information: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/cftss_prep_billing.pdf
15	Waiver Transition	Please clarify how long waiver children are authorized for CFTSS. Are they authorized to receive the cross-walked services for one year from initial CANS?	CFTSS are Medicaid State Plan services. Any child on Medicaid can receive these services as long as they continue to meet medical necessity. Waiver eligibility is not required for access to CFTSS.
16	Waiver Transition	Will Waiver HCBS Providers who bill Managed Care for cross-walked CFTSS be required to submit Plans of Care to MMCP's?	Plans of Care for Waiver children will need to be submitted to MMCPs beginning 30 days before HCBS become part of the managed care benefit package, currently targeted for July 1, 2019. Plans of Care include a list of all services the child is receiving, including CFTSS.

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			Plans of Care are separate than the required Treatment Plans for CFTSS. Treatment Plans for CFTSS are not required to be submitted to MMCPs, however, the information necessary to demonstrate medical necessity criteria may need to be submitted to the MMCP for concurrent authorization. Please refer to MMCP specific authorization requirements at: https://ctacny.org/sites/default/files/UM%20Authorization%20Grid%203%20CFTSS%20jan%2015.pdf
17	Waiver Transition	Please provide billing guidelines for billing the Waiver/B2H - Health Home transition rates.	A Health Home Transitional webinar was conducted on January 16, 2019 for existing providers.