NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services | Office for People With Developmental Disabilities

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

Below is an FAQ concerning the Billing and Revenue Cycle Management Training for the Children and Family Treatment and Support Services that went 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	Who needs to authorize treatment plans, DOH or the Medicaid Managed Care Plans?	Medicaid Managed Care Plans (MMCP) will be authorizing services for children enrolled in managed care. Each MMCP will develop a process by which providers will obtain authorization in line with the State issued utilization management guidelines. Specific MMCP processes for authorization can be found at: https://ctacny.org/sites/default/files/UM%20Authorization%20Grid%203%20CFTSS%20jan%2015.pdf

#	Topic	Question	State Response
2	Billing Limits/Units	Can you bill for the same family for group and individual in the same day for FPSS? If so, can you charge the out of office add-on for both if they are both off-site?	Yes, you can bill for group and individual FPSS on the same day but you cannot charge the off-site twice if both appointments are in the same place back to back. However, if the provider had to travel twice in the same day to deliver services, providers may charge for off-site for both services.
3	Billing Limits/Units	For OLP Crisis Triage, which has a 15 minute unit, what should be done if the call is less than 15 minutes? Can this be 5 minutes instead?	It is anticipated that Crisis calls usually take more than 15 minutes. Providers will not be able to bill for crisis triage call that are less than 15 minutes.
4	Billing Limits/Units	How do you bill for more than one OLP evaluation?	There is not a set limit in the billing manual. Providers should follow billing procedures as outlined in the billing manual.
5	Billing Limits/Units	Why is only OLP Crisis Complex Care in 5 min units/max 20 minutes? Was it not agreed that all crisis OLP services would be kept consistent in terms of units and increments?	Crisis Complex Care (Follow Up to Crisis) is meant to be a brief follow up call post crisis services.

#	Topic	Question	State Response
6	Billing Limits/Units	Are we allowed to provide multiple Children and Family Treatment and Support Services in a day?	Yes, multiple CFTSS can be provided on the same day.
7	Claims	Do you need a diagnosis to bill for OLP (Other Licensed Practitioner)?	You do not need a diagnosis to bill for OLP Evaluation. You should use R69 (or for United F99) in field 67 of the paper claim form that service. If you have seen the individual many times, it is likely a diagnosis would be determined and you would no longer be using R69.
8	Claims	If a field on the claims form is not required and you complete it anyway, what will happen? For example if a field is required for one plan but not others and you set your default to fill it the way it is required for that one plan will the others deny you because you have completed a field that is not required?	Many plans will just ignore it and it will not disrupt the claim, but for some plans, it could lead to a denial. Claim testing is a great opportunity to determine the appropriate system set up to reduce denials.

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9	Codes	How will clinicians know which codes to use?	It can be beneficial to create a Chargemaster that everyone at your organization has access to so that they understand which codes are used for which services as well as who (in terms of licensure) can provide and bill for each service. For more information, view the Creating a Chargemaster webinar.
10	Conflict Free	Can supervisors be shared across services for Children and Family Treatment and Support Services (CFTSS)? What about case managers?	Yes, supervisors and managers can be shared across CFTSS. If you are sharing individuals across CFTSS make sure that staff charges/expenses are appropriately allocated. There are not conflict-free requirements restricting supervisors from being shared across CFTSS providers and care managers (this restriction only applies to HCBS), however this is not a recommended practice.

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11	Conflict Free	At an OMH licensed clinic can someone other than the Other Licensed Practitioner (OLP) recommend to the Children and Family Treatment and Support Services (CFTSS) within the same agency or is that a conflict?	This is not considered a conflict for CFTSS, however it is recommended that individuals be given a choice and only Licensed Practitioner of the Healing Arts (LPHA) can make a recommendation.
12	Designation	When/how are Medicaid Managed Care Plans being informed of designation for children's services? Are they being informed of specific populations and services?	The State shared updated designation lists with the MMCPs on a monthly basis which includes the services, sites, and populations for which agencies have been designated. Medicaid Managed Care Plans have begun contacting with providers. However, it is strongly recommended that providers reach out to MMCP directly if MMCPs have not reached out to the provider directly. For more information, please use the Managed Care Plan Matrix for MMCP contact information.

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13	Eligibility	How often do you recommend doing a batch upload to check Medicaid eligibility?	It is possible to do batch uploads daily, however this is not recommended. Your organization should determine how often is worthwhile (cost vs. benefit) based on the error rate you are getting. It is a best practice to check the individual's Medicaid status prior to service delivery and as close to the appointment as possible (e.g. the morning of the scheduled appointment, night before, etc.).
14	Managed Care	Is there a set timeframe for submitting a claim? Are there timeframes for resolving denials or other claims issues (not billed, pending, etc.)?	The state requires providers be given a minimum of 90 days to submit a claim. It is recommended that providers have a process in place to make sure that every service has been billed in a timely fashion. In addition, the process should include review of remittances (response from MMCP). The goal is to account for every service and its billing status.

#	Topic	Question	State Response
15	Medicaid Enrollment	How do you become a Medicaid provider as part of an agency? Do you have to complete a lengthy application? Can individuals providing CFTSS or HCBS who are not licensed practitioners get NPIs?	Both the organization where care is being provided and identified licensed practitioners individually need to be enrolled as Medicaid providers in order to bill Medicaid if the individual is an enrollable provider type. For more information, we recommend you listen to and review the following webinar, Medicaid Provider Enrollment for CFTSS and Children's HCBS webinar Any individual practitioner can obtain an NPI number, but only certain practitioner types may enroll in Medicaid to obtain an MMIS number. For more information, please see the following links: ▪ Provider Presentation on 21st Century Cures Act ▪ FFS Medicaid Enrollment for OMH BH Providers in MMC Networks

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16	Medicaid Enrollment	Does a provider need a different Medicaid number as a Children and Family Treatment and Support Services provider if they are currently an enrolled provider for a program (i.e. PROS)?	Providers already enrolled in Medicaid do not need to re-enroll. The State will add the appropriate Category of Service code for the providers who have been designated for children's services. The only time an agency would need to complete a Medicaid application is if the agency is brand new and those providers should refer to the webinar at the following link for more information: Medicaid Provider Enrollment for CFTSS and Children's HCBS webinar.

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17	Offsite	Do you need authorization for offsite, separately from service authorization?	Please discuss with your Managed Care Plan to determine their rules.
18	Offsite	What is included in offsite? Is it per site or per unit/per client?	The off-site rate supplements the base service rate to account for additional costs associated with off-site billing. The base service rate codes and the off-site rate codes that correspond should be billed for the number of units the service was provided. The rates are billed per client. These rate codes will be billed on separate claims.
19	Rates	How long will providers get the transition rate?	Providers will get a transition rate for 24 months from the transition date of 1/1/19. The rate will phase out over these 24 months, with reductions every six months.

#	Topic	Question	State Response
20	Third Party Insurance	If a child has multiple insurances, does a provider have to bill their commercial insurance first or can they just bill Medicaid?	Commercial insurance should be billed first because Medicaid is a payer of last resort. Even if it is a service that you know the other insurance will most likely not cover you should bill that insurance first and get denied and then bill Medicaid. Talk with your legal and compliance experts.