Introduction

The New York State Department of Health (SDOH), Office of Mental Health (OHM), and Office of Alcoholism and Substance Abuse Services (OASAS) has created a policy, effective April 1, 2018, for purposes of improving access to Adult Behavioral Health Home and Community-Based Services (BH HCBS) for HARP and HARP-Eligible HIV Special Needs Plan members not enrolled in Health Homes.

To ensure HARP members and HARP-Eligible HIV SNP members who are not currently enrolled in a Health Home are given the opportunity to access Adult BH HCBS, the State has established processes and protocols for HARPs and HIV SNPs contracting with State Designated Entities (SDEs). Effective April 1, 2018, in accordance with Appendix T of the Medicaid Managed Care/Family Health Plus/HIV SNP/Health and Recovery Plan Model Contract, HARPs and HIV SNPs will contract directly with State Designated Entities (SDEs) for the purposes of performing Adult BH HCBS assessment, referral, and HCBS Plan of Care development for HARP members that are not currently enrolled in a Health Home.

The following entities are authorized as State Designated Entities (SDEs):

Agencies or community-based organizations that are State-designated Health Homes, or affiliated with a Health Home, and who employ individuals meeting the NYS assessor qualifications for Adult BH HCBS. An agency is considered affiliated with a Health Home when the agency has a contractual relationship with a NYS-designated Health Home for the provision of health home care management services. The State will provide a list of all State Designated Entities eligible to contract as Recovery Coordination Agencies (RCA) for Adult BH HCBS.

Individuals providing assessment and care planning for contracted RCAs are referred to as Recovery Coordinators.

Plan of Care, Claims Billing, and Coding Tips:

Fidelis Care requires RCAs to use the New York State OMH provided Plan of Care form to be submitted by the RCA, and submission of this documentation is required to remit claims payment. Providers can submit the POC form to the secure email HARPHCBSRCA@fideliscare.org or secure eFax (718-412-8788). The HCBS Plan of Care Template can be found here: [https://www.fideliscare.org/Portals/0/DocumentLibrary/Providers/Resources/201806FidelisCareAdultBHHCBSPlanofCareForm.pdf](https://www.fideliscare.org/Portals/0/DocumentLibrary/Providers/Resources/201806FidelisCareAdultBHHCBSPlanofCareForm.pdf)

Please see the following instructions that support the billing and coding details around the Brief Eligibility Assessment, Initial and Ongoing Plan of Care development, and the allowable transportation codes:

Important requirements when submitting HCBS Claims:

- Providers must submit claims on 837i or UB-04 ‘Facility’ claim forms.
- Providers should submit one rate code and one date of service per claim, and use revenue codes 900 or 911.
- Providers must enter the most current and specific diagnosis code when submitting their claims.
- Be sure to include the authorization / notification information when submitting claims for reimbursement.
- Use the appropriate combination of units and modifiers to correspond with the HCBS rate code for the service provided.
BH Contact Information for Billing and Claims Questions:

Contact the Provider Call Center at 1-888-FIDELIS (1-888-343-3547) and follow the prompts.

BH Authorizations:

By Phone: 1-888-FIDELIS (1-888-343-3547), or
By Fax: (BH) 1-718-896-1784
(HARP) 1-347-868-6427

Providers are required to conduct services consistent with the requirements specified by SDOH/OMH, with additional guidance referenced here SDE-RCA State Guidance

Important Links to Reference:

Adult Behavioral Health Home and Community Based Services Provider Manual
HARP-Mainstream Billing Manual
MCTAC Interactive UB-04 Billing Tool
SDE-RCA State Guidance

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Rate Code Description</th>
<th>Procedure Code</th>
<th>Procedure Code Description</th>
<th>Modifier</th>
<th>Unit Measure</th>
<th>COS</th>
<th>Upstate Rate</th>
<th>Downstate Rate</th>
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<tbody>
<tr>
<td>7778</td>
<td>HCBS Brief Assessment</td>
<td>H0002</td>
<td>Behavioral health screening to determine eligibility for admission to treatment program</td>
<td>HH</td>
<td>Per diem, can only be billed 3 times per 365 days</td>
<td>0220 0268</td>
<td>$71.33</td>
<td>$80.00</td>
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<tr>
<td>7780</td>
<td>Plan of Care Development-Initial</td>
<td>T2024</td>
<td>Service assessment/ Plan of Care Development</td>
<td>None, code 1 unit</td>
<td>0220 0265</td>
<td>$289.77</td>
<td>$325.00</td>
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<tr>
<td>7781</td>
<td>Plan of Care Development-Ongoing</td>
<td>T2024</td>
<td>Service assessment/ Plan of Care Development</td>
<td>U1</td>
<td>Per 15 min, max of 8 per day and 48 units per year</td>
<td>0220 0265</td>
<td>$16.49</td>
<td>$18.50</td>
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<tr>
<td>7806</td>
<td>HARP HCBS Provider Travel Supplement (per mile)</td>
<td>A0160</td>
<td>Non-emergency transportation: per mile - case worker or social worker</td>
<td>Per mile</td>
<td>0220</td>
<td>$0.52 and $.56 (with admin for MCO pass through only)</td>
<td>$0.58 and $.62 (with admin for MCO pass through only)</td>
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<td>Per round trip</td>
<td>0220</td>
<td>$4.90 and $5.26 (with admin - for MCO pass through only)</td>
<td>$5.50 and $5.90 (with admin - for MCO pass through only)</td>
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