TIP SHEET: Medicaid and HealthierLife: Behavioral Health (BH) Carve-in and Health and Recovery Plan (HARP) HCBS Claims

Effective October 1, 2015 (NYC only), and July 1, 2016 (Rest of NYS), Fidelis Care began managing a new Health and Recovery Plan (HARP) for eligible members, as well as expanded Behavioral Health (BH) services that were carved into the Medicaid Managed Care service model for eligible members 21 and older.

The Fidelis Care Health and Recovery Plan (HARP) product is called “HealthierLife” and provides members who qualify with all of the standard Medicaid benefits, along with comprehensive care management, access to Health Homes, and certain enhanced BH services commonly referred to as Home and Community Based Services (HCBS). HCBS services were subsequently added to the HealthierLife benefit package on January 1, 2016 (NYC area), and October 1, 2016 (Rest of NYS). The focus of the program is to provide additional assistance and resources to individuals with serious mental illness (SMI) and/or substance use disorders (SUDs) diagnosis, with an emphasis on recovery and coordinated care.

COVERED SERVICES

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<th>HealthierLife (HARP) HCBS Benefits</th>
<th>Medicaid and Healthier Life (HARP) BH Carve-in Benefits</th>
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<td>Community Psychiatric Support and Treatment (CPST)</td>
<td>Assertive Community Treatment (ACT)</td>
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<tr>
<td>Comprehensive Behavioral Health and Medical Benefits</td>
<td>Comprehensive psychiatric emergency program (CPEP)</td>
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<td>Education Support Services</td>
<td>Continuing day treatment program (CDTP)</td>
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<td>Empowerment Services – Peer Supports</td>
<td>Health Home Care Coordination and Management</td>
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<td>Family Support and Training</td>
<td>Inpatient hospital detoxification service</td>
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<td>Habilitation/Residential Support Services</td>
<td>Inpatient medically supervised inpatient detoxification</td>
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<td>Intensive Crisis Respite Services</td>
<td>Inpatient psychiatric services (OMH)</td>
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<td>Intensive Supported Employment</td>
<td>Inpatient treatment services (OASAS)</td>
</tr>
<tr>
<td>Mobile Crisis Intervention</td>
<td>Intensive Case Management/Supportive Case Management</td>
</tr>
<tr>
<td>Non-Medical Transportation</td>
<td>Medically supervised outpatient withdrawal services</td>
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<tr>
<td>Ongoing Supported Employment</td>
<td>Outpatient clinic and opioid treatment program</td>
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<tr>
<td>Pre-vocational Services</td>
<td>Outpatient clinic services</td>
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<tr>
<td>Psychosocial Rehabilitation</td>
<td>Partial hospitalization program (PHP)</td>
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<td>Short Term Crisis Respite Services</td>
<td>Personalized recovery oriented services (PROS)</td>
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<td>Transitional Employment</td>
<td>Rehabilitation services for residential SUD treatment supports (OASAS)</td>
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QUICK LINKS

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Authorizations and Care Management
MCTAC/CTAC
Form UB-04 Billing Tool
Claims Submission and Payment
Appeals and Requests for Administrative Reviews
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Common Denial Reasons
Steps to Take if Claims are Denied
NYS Resources
Terminology
FAQ’s – BH/HARP Provider Questions
Provider Access Online (provider portal)
Provider Access Online – Obtaining a User Account
BEHAVIORAL HEALTH KEY CONTACT INFORMATION

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<th>Provider Call Center</th>
<th>1-888-FIDELIS (1-888-343-3547), select your language, and choose “2” for Providers</th>
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<tr>
<td>Member Services</td>
<td>1-888-FIDELIS (1-888-343-3547), select your language, and choose “1” for Members</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>1-888-FIDELIS (1-888-343-3547), select your language and choose “2” for Providers, followed by “2” for Services that Require Authorization and “1” for Behavioral Health Services</td>
</tr>
<tr>
<td>BH Billing and Claims Questions</td>
<td><a href="mailto:FCNYBHClaimInquiries@fideliscare.org">FCNYBHClaimInquiries@fideliscare.org</a> 1-888-FIDELIS (1-888-343-3547), select your language, and choose “2” for Providers</td>
</tr>
<tr>
<td>Caremark Pharmacy</td>
<td>1-800-345-5413</td>
</tr>
<tr>
<td>Care / Case Management (Behavioral Health)</td>
<td>1-888-FIDELIS (1-888-343-3547) and choose option “3” after selecting “1” for Members</td>
</tr>
</tbody>
</table>

HEALTHIERLIFE MEMBER ELIGIBILITY CRITERIA

- All Medicaid beneficiaries, not enrolled in a Dual Medicaid and Medicare plan, who are 21 and over, who have been assigned eligibility from the State DOH based on historical utilization of mental health and/or substance use disorder treatment.
- Check the member's ID card and logon to our provider portal, Provider Access Online, to verify current eligibility and coverage details: [https://providers.fideliscare.org](https://providers.fideliscare.org) or contact the Fidelis Care Provider Call Center and use the automated eligibility tool at 1-888-FIDELIS (1-888-343-3547) and follow the prompts.

AUTHORIZATIONS

<table>
<thead>
<tr>
<th>Authorization Request Contact Information</th>
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<tbody>
<tr>
<td>Phone</td>
</tr>
<tr>
<td>1-888-FIDELIS (1-888-343-3547) and follow the prompts</td>
</tr>
</tbody>
</table>

Provider Access Online

BH/HARP providers can search on 'Patient', scroll to bottom and 'Create Authorization’ online.

Authorization Grid

AUTHORIZATIONS AND CARE MANAGEMENT

- Each HealthierLife member is assigned a Care Manager who is responsible for establishing and leading the member’s Interdisciplinary Care Team (IDT). The IDT can also include the member's assigned Health Home Care Manager, PCP, BH provider, AOT Case Monitors (if applicable), the Member's Designee and other health care professionals needed to address the member’s needs.
- The Care Manager, in conjunction with the IDT, are responsible for developing the Person Centered Service Plan (PCSP), which is a written description in the care management record which specifies the member’s specific health care goals to be achieved and the amount, duration, and scope of the covered services and is the basis upon which all services are authorized.
- Medically necessary services that are not listed in the PCSP may require authorization. To determine which services require authorization, please refer to the Authorization Grids which can be found at [http://www.fideliscare.org/en-us/providers/authorizationgrid.aspx](http://www.fideliscare.org/en-us/providers/authorizationgrid.aspx).
- BH authorizations can be requested by phone at 1-888-FIDELIS (1-888-343-3547) or by fax at (BH) 1-718-896-1784, (HARP) 1-347-868-6427.
- When referring for covered services, please ensure that the provider is participating in the Fidelis Care network or is subcontracted with a participating Health Home. Participation can be verified by visiting [http://www.fideliscare.org/apps/providersearch/](http://www.fideliscare.org/apps/providersearch/).
- Pre-authorization requests are processed by the Fidelis Care Quality Health Care Management (QHCM) Department. We recommend that requests be sent at least five (5) calendar days before the anticipated date of service. Standard requests are responded to within three (3) business days, as long as additional information is not necessary.
The Community Technical Assistance Center of New York (CTAC) and the Managed Care Technical Assistance Center of New York (MCTAC) are training, consultation, and educational resource centers serving all behavioral health agencies in New York State. They help agencies strengthen their clinical and business infrastructure through training opportunities focused on implementing evidence-based practices and addressing the challenges associated with the recent changes in regulations, financing and overall healthcare reforms.

Form UB-04 Billing Tool

The MCTAC Billing tool is an interactive UB-04 form that walks through the components required to submit a clean claim. Whether you are new to the process or just want to quickly check one field, the billing tool is the ideal reference. The tool will tell you what information is required for each field and will note specific plans’ requirements.

Please note this guidance applies to outpatient/ambulatory services only.

Hover over or click each numbered field for more information. (sample of interactive form below)
CLAIMS SUBMISSION AND PAYMENT

Claim Submission Routes

Fidelis Care claims can be submitted in several different ways. To service our provider/submitters in the most efficient manner, the list below indicates the order of most preferred* to least preferred:

1. Clearinghouse Submission
2. Billing Service Submission
3. Direct Submission *(200 claims per month minimum)*
4. Co-Branded Portal *(professional claims only accepted)*
5. Claims Online Portal *(professional and institutional claims accepted)*
6. Paper Submission

<table>
<thead>
<tr>
<th>*Electronic Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fidelis Care Payer ID – 11315</td>
</tr>
<tr>
<td>For more information visit: fideliscare.org / Providers / Electronic Submissions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paper Claims - HealthierLife</th>
<th>Paper Claims – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fidelis Care HealthierLife P.O. Box 1205 Amherst NY 14226-1205</td>
<td>Fidelis Care Corporate Claims Dept P.O. Box 806 Amherst NY 14226-0806</td>
</tr>
</tbody>
</table>

- All claims must be submitted within ninety (90) days from the date of service.
- Claim are processed within thirty (30) days after receipt of a clean claim submitted electronically and forty-five (45) days after receipt of a clean paper claim *(Note: A "Clean Claim" is a claim for health care services that contains all required data elements).*
- Participating providers may not, under any circumstance, bill a Fidelis Care member for any covered services.
- To obtain the status of a claim or a copy of a claim remittance advice, please visit Provider Access Online at https://providers.fideliscare.org
- For detailed billing instructions, including field by field guidance on completing a UB04 claim form, please visit http://mctac.org

APPEALS AND REQUESTS FOR ADMINISTRATIVE REVIEWS

Medical Necessity Standard Appeals

Appeals must be received within sixty (60) business days of the remittance advice and should be mailed to: Attn: Appeals Department, Fidelis Care, 490 CrossPoint Parkway, Getzville, NY 14068, Phone: 718-896-6500 ext. 13159, Fax: 718-393-6779

Requests for Administrative Review of Previously Processed Claim

Requests for claims reconsiderations must be submitted within sixty (60) calendar days of the date of the remittance advice. Requests for administrative review must be sent to the following address: Attn: Claims Reconsideration, Fidelis Care, 480 CrossPoint Parkway, Getzville, NY 14068

Please visit Fidelis Care’s website, fideliscare.org, for a complete Fidelis Care Provider Manual, Authorization Grids, educational resources, announcements, participating provider search engine, and other helpful tools.
COMMON CLAIM BILLING ERRORS

<table>
<thead>
<tr>
<th>Billing Issues</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rate code inconsistent with units</strong></td>
<td>Coding Taxonomy</td>
</tr>
<tr>
<td>Required <strong>modifier</strong> is missing</td>
<td>Coding Taxonomy</td>
</tr>
<tr>
<td><strong>Value/Rate Codes</strong> missing or invalid</td>
<td>Coding Taxonomy</td>
</tr>
<tr>
<td>(Value Code = 24 / Rate Code – refer to Coding Taxonomy link)</td>
<td>Coding Taxonomy</td>
</tr>
<tr>
<td>Only <strong>one (1) rate code</strong> allowed per claim.</td>
<td></td>
</tr>
</tbody>
</table>

COMMON DENIAL REASONS

<table>
<thead>
<tr>
<th>Denial Definitions</th>
<th></th>
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<tbody>
<tr>
<td>CDD, 510</td>
<td>Duplicate Claim</td>
</tr>
<tr>
<td>568</td>
<td>Invalid Procedure Code/Rate Code</td>
</tr>
<tr>
<td>S12, S13, S23, ST</td>
<td>Member has no active coverage on Date of Service</td>
</tr>
<tr>
<td>X09</td>
<td>No prior authorization</td>
</tr>
<tr>
<td>TFO</td>
<td>Timely filing: Claims must be submitted within 90 days of Date of Service</td>
</tr>
<tr>
<td>X06</td>
<td>Denials for Medicaid fee-for-service benefit (Members under 21 yrs)…. (should bill NYS Medicaid)</td>
</tr>
</tbody>
</table>

STEPS TO TAKE IF CLAIMS ARE DENIED

1. **Review Denial Reason**
   a. Upon review of denial reason, ensure member has active coverage with Fidelis, and that the service was eligible to be billed to Fidelis Care and not NYS Fee-for-Service (FFS). Members age 20 and younger continue to receive some services through FFS and claims need to be submitted through eMedNY.

2. **Review Coding Crosswalk and Billing Manual**
   a. Check for accurate rate codes, procedure codes, modifiers, and units for each service billed.
   b. Submit Corrected Claims. Refer to **Section Twelve – Part 1** of the Provider Manual for instructions on how to submit corrected claims to Fidelis Care.

3. **Unsure about the specific steps to get your claim corrected?**
   a. Gather information about your claims including claim IDs and other reference points, and email our dedicated Behavioral Health Claiming team at FCNYBHClaimInquiries@fideliscare.org, OR
   b. Call 1-888-FIDELIS (1-888-343-3547) and follow the prompts to get started working with a Provider Relations Representative who can assist with gathering the information needed to investigate your claiming issue thoroughly.
NYS RESOURCES

MCTAC/CTAC Resources

Adult Behavioral Health Home and Community Based Services Manual (Provider Manual)
Behavioral Health Outpatient Revenue Codes
Comprehensive Psychiatric Emergency Programs (CPEP) and Extended OBs Beds (EOBs)
New York City BH HCBS Fee Schedule
Rest of State BH HCBS Fee Schedule
HARP/Mainstream Billing and Coding Manual
Coding Taxonomy
OMH Government Rates Table
Other NYS mctac/ctac Resources (scroll to bottom of screen)

TERMINOLOGY

Terminology – Language Guide (mctac/ctac)

ACO – Accountable Care Organization
ACT – Assertive Community Treatment
BIP – Balancing Incentive Plan
CDTP – Continuing Day Treatment Program
CPEP – Comprehensive Psychiatric Emergency Program
CPST – Community Psychiatric Support and Treatment
DISCO – Developmental disability Individual Support and Care Coordination Organizations
DSRIP – Delivery System Reform Incentive Payment
FIDA – Fully Integrated Dual Advantage
HARP – Health and Recovery Plan
HCBS – Home and Community Based Services
HH – Health Home
LGU – Local governmental Unit
LOC – Level of Care
LOCADTR – Level of Care for Alcohol and Drug Treatment Referral
MCTAC – Managed Care Technical Assistance Center
MLR – Medical Loss Ratio
MLTC – Managed Long Term Care
MRT – Medicaid Redesign Team
OASAS – Office of Alcohol and Substance Abuse Services
OMH – Office of Mental Health
PCMH – Patient-centered Medical Homes
PMPM – Per Member Per month
PPS – Performing Provider System
PROS – Personalized Recovery Oriented Services
RCM – Revenue Cycle Management
Rev Code - Revenue Code, 3-digit number (may be preceded by a “0”) Field 42 on UB-04 form which describes the type of service performed. (Example: 0450 – Emergency Room)
RPC – Regional BH Planning Consortium
SPA – State Plan Amendment
UM – Utilization Management
FAQ's – BH/HARP Provider Questions

Top Behavioral Health Utilization Management Related Inquiries:

Q1: Where can providers send questions or inquiries about Utilization Management for Behavioral Health?
A1: Providers can send inquiries to QHCMHARPBH@fideliscare.org

Q2: What are the different ways to request authorization? (Phone, Fax, PPA- how to get access to Portal, etc).
A2: Providers can request authorization at 1-888-FIDELIS (1-888-343-3547) ext. 16072 for Mainstream and ext. 16077 for HARP members; by fax at 1-718-896-1784, or by email QHCMHARPBH@fideliscare.org
Providers can also create an account for the Provider Portal and request authorizations through the online portal

Q3: What clinical information is needed to complete an authorization request?
A3: Member demographics, Facility Tax ID and address, diagnosis, and various clinical material depending on the type of service being requested (examples include LOCADTR, Withdrawal evaluation, current treatment plan, Mental Status Exam, current and past medication history, discharge plan, etc.)

Q4: How do I know if the service I’m delivering requires an authorization?
A4: See page 36 of the Provider Manual - Behavioral Health – Section 21 for a description of services and if Prior Authorization or Concurrent Authorization is required. A detailed description of services and their related codes that need authorization can also be found in the BH Authorization Grid.

Links/reference to relevant resources:
MCTAC/CTAC
Provider Manual- BH Section

Provider Access Online (provider portal):

What is Provider Access Online?
As your partner in quality care, Fidelis Care wants to make sure you have the tools and resources you need to provide your patients with the care and services they deserve. Our enhanced provider portal, Provider Access Online (PAO), is a critical part of Fidelis Care’s efforts to increase efficiency and expand services to our providers.

Provider Access Online benefits include:

- Verify member eligibility
- Check claims status
- Check authorizations status
- Download Rosters, Remittance Advices and other important documents
- Search for other participating providers
- Receive the latest Fidelis Care updates via the PAO Informational Blog

Your satisfaction is our priority and we trust you will find PAO to be a valuable and helpful tool and resource. Click here to access Provider Access Online.

For assistance accessing PAO please contact your Provider Relations Representative or contact Fidelis Care’s Provider Call Center at 1-888-FIDELIS (1-888-343-3547).
Obtaining a User Account

Thank you for your interest in obtaining a user account for Fidelis Care’s provider portal. For information on gaining access to PAO please see below:

- One or more individuals at your organization must be designated as an Account Administrator. An Account Administrator can add you as a new user or as another Account Administrator.
- If you are unsure if anyone within your organization is an Account Administrator, contact Fidelis Care’s Provider Call Center at 1-888-FIDELIS (1-888-343-3547). We can check whether an Account Administrator has been established and let you know who that person is.
- If you are certain that there is no Account Administrator or if you are the designated Account Administrator and you need assistance accessing PAO, please contact Fidelis Care’s Provider Call Center at 1-888-FIDELIS (1-888-343-3547). If you are a participating provider within the Fidelis Care network, your Provider Relations Representative can also help.
- If you are a third-party representative (e.g. a billing company) for a provider, then you will need to have an Account Administrator at the provider’s office create a user account for you. Please see below for more information on granting access for billing companies.

Providers Granting Access For Billing Companies

With Provider Access Online, one or more individuals at your provider organization must be designated as an Account Administrator. An Account Administrator can add new users and/or additional Account Administrators. If you are working with a third party representative (e.g. a billing company), then you will need to have an Account Administrator in your office create a user account for them as well. If the third party company needs to add multiple users, it may be beneficial to add an Account Administrator in that office so they can add users as needed. Third party companies will not have access to any claims or patient information until they are set up in Provider Access Online by the provider’s Account Administrator. Please be proactive in understanding what information your billing companies may need and what users need to be added. Access can be assigned by logging in and creating a new user. If you have any questions about logging in for the first time, please contact Fidelis Care’s Provider Call Center at 1-888-FIDELIS (1-888-343-3547).