Guide to Billing Health Home Claims

EmblemHealth®

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Definitions

AOT — assisted outpatient treatment

CMA — case management agency

CANS-NY — Child and Adolescent Needs and Strengths – NY

CIN — client identification number

DOS — date(s) of service

EDI — electronic data interchange

FFP — federal financial participation

HH+ — Health Home Plus

HCPCS — Healthcare Common Procedure Coding System

HML — high, medium, and low

MCO — managed care organization

MAPP HHTS — Medicaid Analytics Performance Portal Health Home Tracking System

NPI — National Provider Identifier

PNC — PNC Remittance Advantage

EFT — electronic fund transfer

Health Home Billing Tips

Health Homes (HH) claims should be submitted using electronic formats.

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, institutional providers who submit claims electronically are required to use the HIPAA 837 Institutional (837i) transaction. This is the preferred method of claims transmission.

837 transactions will be validated as follows. It's important to adhere to these guidelines:

- MMIS-ID
  - Billing provider's NPI.
  - Billing provider's 9-digit ZIP Code.
    - The combination of NPI and ZIP+4 are expected.
- Rate Code
  - The Rate Code must be one previously approved for HH services.
  - Some HH Rate Codes may not be payable by EmblemHealth and must be billed directly to eMedNY (example Rate Code 1861).

- The following Status Code(s) will be sent in the 277CA Response whenever the validation fails.
  - Status Code 132 will indicate an issue with either the NPI or the 9-digit ZIP code.
  - Status Code 116 will indicate the potential to submit to eMedNY.
  - Status Code 726 will indicate the Value Information Amount (Rate Code) that needs to be corrected.

- Other parameters chosen to facilitate the validation of HH claims but not enforced currently:
  - Taxonomy Code – This segment is expected in Loop 2000: PRV*BI*PXC*251B00000X~
  - Facility Type Code – As per the Department of Health's (DOH) guidance, only "34" is expected.
  - Claim Filing Indicator Code (SBR09) can be any compliant value, but most providers will send "HM."

- Date of Service (DOS) must be on or after the implementation date (July 1, 2018). However, claims submitted with DOS before this date will not be rejected by the 277CA front-end edit. Instead, they will be reported as DENIED in the 835-Electronic Remittance Advice with CARC 109: Claim/service not covered by this payer/ contractor. You must send the claim/service to the correct payer/contractor.

- Adjustments and Voids
  - EmblemHealth will process Adjustments/Voids sent on the 837I. All 837 claims will be validated by interrogating the Claim Frequency Code (CLM05-3).
    - New/Original claims are identified by a value of "1."
    - Adjustment claims are identified by a value of "7."
    - Void claims are identified by a value of "8."
  - Whenever EmblemHealth receives CLM05-3 = 7 or 8, it is expected that the provider will also send EmblemHealth's Claim Number in REF*F8 of Loop 2300 for the previously "paid" claim.
  - EmblemHealth's Claim Number is provided in CLP07 of the 835-Remittance Advice for all paid claims. The claim number must be valid/found; otherwise, the claim transaction will be rejected by the front-end 277CA with Status Code 35 (35 = Claim/Encounter not found).

- Review Frequently Asked Questions About Claims Payment Processing By PNC/ECHO Health **here**.

- The UB-04 may be used when applicable and in accordance with plan-specific guidance.

- If you must use a paper claim, the UB-04 is the correct type of claim form. Please do not use UB-92 or CMS- 1500 forms. The bill type for the UB-04 will be 34x.

- Submit paper claims on red "drop out" forms. Forms should be typed, not handwritten.

- Complete only required fields. Entry in fields that are not required may result in your claim being denied.

- Review your Agreement to verify the types of services you have contracted and the amount you should expect to be reimbursed per the contractual agreement.

- Services performed on the same date of service and/or same hour should be billed on the same claim.

- EmblemHealth uses the Medicaid client identification number (CIN) as the member ID number for its Medicaid and HARP members. This is what you should use as the unique identifier.

- Be sure to bill the units as appropriate for each type of service.

- National Provider Identifier (NPI) must be used on every claim. According to the New York State Department of Health (NYSDOH), NPI will be used to identify case management agencies (CMAs). Supplemental guidance will be issued to accompany the taxonomy grid in Attachment A.

- Face-to-face contact is defined as an in-person meeting with the member and/or parent, guardian, or legally authorized representative who has the authority to consent and enroll.

- Telephonic contact is defined as a communication method that is used to talk directly to the member and/or parent, guardian, or legally authorized representative who has the authority to consent and enroll.

- EmblemHealth provides processes for members and practitioners to dispute a determination that results in a denial of payment and/or covered services. Process, terminology, filing instructions, applicable time frames, and additional and/or external review rights vary based on the type of plan in which the member is enrolled. For detailed information, visit the Dispute Resolution for Medicaid Managed Care Plans chapter of the EmblemHealth **Provider Manual**.

- Billing timeframes:
  - Electronic claims will be processed within 30 days of date of receipt if a clean claim.
  - Paper claims will be processed within 45 days. Please reference Adjustments and Voids section.
  - Denials will be sent within 30 days regardless if electronic or paper.

Reporting Requirements

EmblemHealth is required to report to the Department of Health each Health Home encounter our members have. To ensure we have the right information from you, please make sure each claim includes the following:

Required Elements for Encounter: Non-inpatient Reporting Requirements:

- a. Date of service
- b. Provider specialty code
- c. Revenue code
- d. Place of service
- e. Procedure code
- f. Modifier (as applicable)
- g. Diagnostic code
- h. Category of service
- i. Units - 1
- j. Charges - corresponding rate
    - i. Transaction segment: Institutional
    - ii. COS-15
    - iii. Provider specialty code 371
    - iv. Rate code

Adult and Child Designation

Coding taxonomy should be used to differentiate Children's Health Home from Adult Health Home bills.

Only Health Homes that have been designated to serve children may bill children's high, medium, and low (HML) rates, as determined by the Child and Adolescent Needs and Strengths – NY (CANS-NY) acuity algorithm, for members under age 21. A monthly Children's Billing Questionnaire in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) must also be completed prior to submitting a Children's Health Home care management claim.

Health Homes that are not designated to serve children who enroll children (anyone under 21) must bill at the adult rate which is determined using the MAPP HHTS Clinical and Functional Assessment (HML Adult Billing Questionnaire).

Any Health Home that serves a member who is 21 or older must bill the appropriate Adult HML Health Home rates. A monthly Adult HML Assessment that is similar to the Children's Billing Questionnaire must be completed in the MAPP HHTS. This also applies to members 21 years and older who elect to be served by a Children's Health Home.

Enrollment rates for adults must be clearly documented in the care management record. Health Homes are required to validate that all claims meet the requirements for the rate billed and supported by the MAPP HHTS Billing Support Download.

EDI Transaction Guide

Electronic Data Interchange (EDI) transactions help practitioners manage their practices more effectively. EmblemHealth supports HIPAA-compliant electronic data interchange transactions.

Electronic claims submission provides an easier, faster way to submit claims. Some of the advantages of electronic claim submission include:

- Quicker claims submission, which means faster reimbursement to you.
- No paper claims to stock and complete.
- Simplified record keeping by eliminating lost claims paperwork.
- Reduced clerical time and the costs to process and mail paper claims. Electronic Remittance Advice* (HIPAA 835 transaction)

* EmblemHealth can provide paper remittances.

The pathways for electronic claims submission to EmblemHealth:

- Practice management system vendors, billing services, and practitioners that submit claims and other EDI transactions via one of EmblemHealth's contracted claims clearinghouses.
- Practice management system vendors and billing services that submit claims and other EDI transactions directly to EmblemHealth.

Important EDI requirements:

- National Provider Identifier (NPI) – Ensure your software is capturing and correctly populating your NPI in your electronic claims. Otherwise, your claims will be rejected (not accepted) by EmblemHealth. If a CMA has an NPI, according to the NYSDOH, the NPI will be used to identify the CMA. Supplemental guidance will be issued to accompany the **taxonomy grid**.
- Payer ID number – Ensure that your claims are routed correctly via your vendor and/or claims clearinghouse. Please refer to the sample 837I file.
- Date(s) of service (DOS) – Ensure the appropriate data items are populated correctly or your claims will be rejected (not accepted) by EmblemHealth.
- ICD-10/CPT4 codes – Helps to ensure the correct settlement of your claims.
- Membership information – Helps to ensure EmblemHealth accepts your claims for covered members.
- Ensure that all transactions transmitted to EmblemHealth each month meet all requirements for acceptance through EmblemHealth's electronic gateway. However, a paper claim is required for processing voids or adjustments.

EDI-related support:

Please call our EDI Operations Call Center at **212-615-4362**, from 9 a.m. to 5 p.m, Monday through Friday, for any questions you may have related to electronic claims submission.

Avoid Duplicate Claims Submissions by Using Your 277CA Report (Claims Rejection Report)

Note: If you submit duplicate claims, you may actually delay claims processing and can potentially create confusion for the member.

EDI Submission Samples

Description of Content
A sample of an 837 institutional (837I) claim that the Health Homes will send to EmblemHealth. **See pages 20-23**.
The first response file EmblemHealth will send to the submitter of the 837I-claim file. This "TA1" response will let the submitter know if the claim file was received and will also let them know whether the file was structurally correct or not. **See page 20**.
We encourage our providers to eliminate paper claims and to submit electronic claims to EmblemHealth in HIPAA-compliant provider institutional provider (837I), EDI claims transaction formats. See EmblemHealth's Guide for Electronic Claims Submission **page 23**.
This is the last response produced by the front-end process. The 277CA validation is performed based on business rules. It will inform the submitter about all the individual claims that made it to this level and whether they were rejected based on a business rule or accepted to go forward to the adjudication system – Facets. **See page 24**.
After claims are adjudicated, the payment and remittances are created.

Service Grid

Revenue Code/HCPCS Combination Examples

This list is not complete and is subject to change.

Please note that this applies to adult HML rate codes only. Outreach, Adult Health Home Plus, Adult Home Plus, and Children's rates remain the same.

Rate Code	Rate Code Description	COS	Provider Specialty Code	Rates Apply to	Revenue Code	Procedure Code	Procedure Code Description	Modifier
1864	Health Home Services - Children (Low)	15	371	Health Homes Serving Children	0500	T2022	Case management, per month	U1
1865	Health Home Services - Children (Medium)	15	371	Health Homes Serving Children	0500	T2022	Case management, per month	U2
1866	Health Home Services - Children (High)	15	371	Health Homes Serving Children	0500	T2022	Case management, per month	U3
1869	Health Home Services - Children (Low) (Inc FFP)	15	371	Health Homes Serving Children	0500	T2022	Case management, per month	U1
1870	Health Home Services - Children (Med) (Inc FFP)	15	371	Health Homes Serving Children	0500	T2022	Case management, per month	U2
1871	Health Home Services - Children (High) (Inc FFP)	15	371	Health Homes Serving Children	0500	T2022	Case management, per month	U3
1868	Health Home-CANS Assessment (Children)	15	371	Health Homes Serving Children	0500	G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	
1853	Health Home Plus/Care Management	15	371	Health Homes Serving Adults	0500	G9005	Coordinated care fee, risk adjusted maintenance	U4
1860	Health Home Services - Adult Home Transition	15	371	HHs Serving Adult Home Class	0500	G9005	Case Management, per month	U3
1861	Adult Home Assessment and Management Fee			Direct HH billing through eMedNY				
1873	Health Home Care Management	15	371	Health Home Serving Adults	0500	G9005	Case Management, per month	U1
1874	Health Home High Risk/ Need Care Management	15	371	Health Home Serving Adults	0500	G9005	Case Management, per month	U2
1875	Home and Community Based Services Assessment Fee	15	371	Health Homes Servicing Children	0500	G506		U1
1867	High Fidelity Wrap (HFW)	15	371	Health Homes Servicing Children	0500	T2022	Case Management per Month	U4
1876	Health Home Plus/AOT (Adults)	15	371	Health Home Serving Adults	0500	G9005	Case Management per Month	U6

Important Note

- All Medicaid Managed Care Plan billing instances must contain the applicable procedure code and modifier where applicable.
- Health Homes Serving Children will continue to follow current billing guidance. Rate codes are separated in the taxonomy to delineate a subpopulation of children meeting complex trauma criteria. This distinction is not necessary for Medicaid Managed Care Plans and therefore the procedure codes and modifiers are identical.

Risk-Adjusted Categories

The following describes when key risk-adjusted category codes should be used.

Health Home Serving Adults

Health Home Care Management (1873/G9005-U1)

This risk-adjusted category must be billed at this rate if the clinical and functional assessment yield a medium or low risk and do not meet any of the following:

- HARP/HIVSNP (HARP eligible).
- Adult Home Plus criteria.
- Health Home Plus criteria.

Health Home High Risk/Need Care Management (1874/ G9005-U2)

This risk-adjusted category will include all HARP and HIV/SNP (HARP eligible) plan enrolled members. These members can be identified by the following restriction exemption codes: H1 H2, H3, H4, H5, or H6. In addition, any member who scores high on the clinical and functional assessment can bill at this rate.

Adult Home Plus (1860/G9005-U3)

This risk-adjusted category is applicable only to the five boroughs of New York City and is guided by separate guidance. Health Homes are responsible for attesting and verifying that the care management agency is approved to serve this population. This subset of Health Home population represents a group of members transitioning from Adult Homes to the community. Health Homes are required to produce documentation to Medicaid Managed Care Plans as requested for the purposes of billing audits. Care Management agencies must indicate that the member meets the Adult Home Plus rate category when completing the MAPP HHTS clinical and functional assessment.

Health Home Plus (1853/G9005-U4)

This risk-adjusted category follows separate guidance distributed in partnership with the Office of Mental Health and the AIDS Institute. This category serves the highest risk members who meet the single qualifying conditions of severe mental illness (SMI) and HIV/AIDS. Meeting the single qualifying condition criteria alone however is not enough to bill at this rate. Members who meet criteria for Health Home Plus (HH+) must also meet additional clinical criteria. In addition, Health Homes must attest that the care management agency employ staff that have the credentials and meet the supervisory qualifications to serve this population. This attestation also requires that Health Homes are verifying that care managers are meeting a minimum of two (2) face-to-face contacts per member per month.* Care management agencies must indicate that the member meets the Health Home Plus rate category when completing the MAPP HHTS clinical and functional assessment. If the care manager has met the minimum contact requirements, this will be documented in the MAPP HHTS by attesting to a core service and indicating that the member meets HH+ criteria.

*Health Home Plus guiding members with an assisted outpatient treatment (AOT) order must meet the requirement of four (4) face-to-face contacts to bill at this rate.

Fee Schedule

The Health Home rates are determined by the NYS Department of Health and are available on the NYS Department of health website at **Health Home Rate Codes**. Rates were provided in advance of final approval and are subject to change.

Health Home Rate Codes

- Rate Codes are also available in Portable Document Format (PDF)

Health Home Rate Codes in Effect for Health Home Services on/after April 1, 2025 ***pending State/Federal approval (Rate changes are highlighted in blue

Rate Code	Rate Description and Applicable To	Revenue Code	Procedure Code	Modifier	Rates Effective April 1, 2023		Rates Effective January 1, 2024		Rates Effective April 1, 2024		Rates Effective April 1, 2025 ***	
					Upstate (1)	Downstate(1)	Upstate (1)	Downstate(1)	Upstate (1)	Downstate(1)	Upstate (1)	Downstate(1)
1853	Health Home Plus/Care Management (Adults)	0500	G9005	U4	$822.12	$876.93	$822.12	$876.93	$845.47	$901.83	$867.45	$925.28
1860	Health Home Services - Adult Home Transition (Adult Home Class Members)(2)	0500	G9005	U3		$800.00		$800.00		$800.00		$800.00
1861	Adult Home Assessment and Management Fee (Adult Home Class Members)(2)	NONE	NONE	NONE		$200.00		$200.00		$200.00		$200.00
1864	Health Home Services - Children (Low)	0500	T2022	U1	$227.25	$242.40	$243.00	$276.00	$243.00	$276.00	$243.00	$276.00
1865	Health Home Services - Children (Medium)	0500	T2022	U2	$454.50	$483.79	$485.00	$553.00	$485.00	$553.00	$485.00	$553.00
1866	Health Home Services - Children (High)	0500	T2022	U3	$757.50	$806.99	$809.00	$921.00	$809.00	$921.00	$809.00	$921.00
1867	High Fidelity Wrap (HFW) (Children)	0500	T2022	U4			$1,228.00	$1,399.00	$1,228.00	$1,399.00	$1,228.00	$1,399.00
1868	Health Home-CANS Assessment (Children)	0500	G0506	NONE	$186.85	$186.85	$186.85	$186.85	$186.85	$186.85	$186.85	$186.85
1869	Health Home Services - Children (Low) (Inc FFP)	0500	T2022	U1	$227.25	$242.40	$243.00	$276.00	$243.00	$276.00	$243.00	$276.00
1870	Health Home Services - Children (Medium) (Inc FFP)	0500	T2022	U2	$454.50	$483.79	$485.00	$553.00	$485.00	$553.00	$485.00	$553.00
1871	Health Home Services - Children (High) (Inc FFP)	0500	T2022	U3	$757.50	$806.99	$809.00	$921.00	$809.00	$921.00	$809.00	$921.00
1873	Health Home Care Management (Adults)	0500	G9005	U1	$202.00	$215.13	$202.00	$215.13	$202.00	$215.13	$202.00	$215.13
1874	Health Home High Risk/Need Care Management (Adults)	0500	G9005	U2	$363.60	$386.83	$363.60	$386.83	$363.60	$386.83	$363.60	$386.83
1875	Home and Community Based Services Assessment Fee (Children)	0500	G0506	U1	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00	$200.00
1876	Health Home Plus/AOT (Adults)	0500	G9005	U6					$1,020.12	$1,086.93	$1046.64	$1115.19

NOTES:

(1) Downstate includes NYC, Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk and Westchester Counties. Upstate includes all other counties

(2) Rates only apply to impacted Adult Home class members

*** Pending State and Federal Approval.

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