



Department  
of Health

Office of  
Mental Health

Office of Addiction  
Services and Supports

Office of Children  
and Family Services

Office for People With  
Developmental Disabilities

# New York State Children's Health and Behavioral Health Medicaid System Transformation

## Billing and Coding Manual

September 2022

Send questions to  
[BH.Transition@health.ny.gov](mailto:BH.Transition@health.ny.gov)

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## General

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The purpose of this manual is to provide billing information regarding the implementation by the New York State Department of Health (NYS DOH), Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), Office of Children and Family Services (OCFS), and Office for People with Developmental Disabilities (OPWDD) of the Children's Health and Behavioral Health System Transformation, which includes Children and Family Treatment Services and Supports (CFTSS) and Children's Home and Community Based Services (HCBS).

The implementation of the services and the transition of benefits and populations to Managed Care included in the Children's Transformation were implemented in a phased approach beginning on January 1, 2019 and included the transition of selected children/youth's benefits to Medicaid Managed Care. These services are available to children/youth, defined as an individual under the age of 21.

This manual applies to services covered by Medicaid Managed Care (MMC) and the Medicaid fee-for-service (FFS) delivery system.<sup>1</sup>

### Purpose of this Manual

This manual outlines the claiming requirements necessary to ensure proper claim submission for services affected by the Children's Health and Behavioral Health System Transformation (CFTSS and HCBS). This manual is intended for use by Medicaid Managed Care Plans (MMCP), including Special Needs Plans (SNP), behavioral health service providers, and HCBS service providers.

This manual provides billing guidance only. It does not supersede applicable regulatory requirements or procedures for admission to a program, record keeping, service documentation, initial and on-going treatment planning and reviews, etc. Contents of this manual are subject to change.

Appendices to this manual include listing of rate code and procedure codes and modifier codes to be used for each service.

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<sup>1</sup> Additional guidance related to Community First Choice Option (CFCO) will be incorporated into this manual at a future date

## Children and Family Treatment and Support Services (CFTSS)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)<sup>2</sup> Medicaid State Plan behavioral health services were phased in and are now available as part of the Medicaid State Plan (please see phase-in date next to each service):

- Other Licensed Practitioners (OLP) – 1/1/2019,
- Community Psychiatric Support and Treatment (CPST) – 1/1/2019,
- Psychosocial Rehabilitation (PSR) – 1/1/2019,
- Family Peer Support Services (FPSS) – 7/1/2019,
- Youth Peer Support (YPS) – 1/1/2020, and
- Crisis Intervention (CI) – 1/1/2020

For children/youth enrolled in Medicaid Managed Care Plans, these services are billed directly to the Plans.

## Children's Home and Community Based Services (HCBS)

Most services previously delivered under agency-specific 1915(c) waivers are now delivered under concurrent waiver authorities that allow children/youth to be enrolled in Managed Care (unless otherwise exempt or excluded for another reason), and the services are included in the Managed Care benefit package. All reimbursement for children/youth's HCBS covered in the Managed Care benefit package will be non-risk until September 30, 2023. At that time, NYS will review and consider an additional extension and confirm this date in writing. The MMCP capitation payment will not include these services.

The following services are available under concurrent waiver authorities for those children/youth who are eligible for and enrolled in HCBS. Additional detail on these services, along with information on eligibility requirements can be found in the [Children's HCBS Manual](#).

HCBS include the following services:

- Adaptive and Assistive Technology
- Caregiver/Family Advocacy and Support Services<sup>3</sup>
- Community Habilitation
- Day Habilitation
- Environmental Modifications

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<sup>2</sup> The EPSDT section of NYS Plan provides for comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is the key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

<sup>3</sup> This is a consolidation of the previous services for "Caregiver Family Support and Services" and "Community Advocacy Training and Supports."

- Non-Medical Transportation<sup>4</sup>
- Palliative Care Counseling and Support Services
- Palliative Care Expressive Therapy
- Palliative Care Massage Therapy
- Palliative Care Pain & Symptom Management
- Pre-Vocational Services
- Respite (Planned & Crisis)
- Supported Employment
- Vehicle Modifications

## Health Home Care Management

On April 1, 2019, children/youth eligible for HCBS began receiving care management through Health Home (HH). The care coordination service that was provided under each of the six legacy children/youth's 1915(c) waivers transitioned to Health Home beginning January 1, 2019.

Health Home is an optional benefit; therefore, children/youth may opt out of Health Home care management. For those that opt out of HH Care Management, the State-designated Independent Entity, Child and Youth Evaluation Service (C-YES), will conduct HCBS Eligibility Determinations and develop a Plan of Care (POC) for HCBS. For children/youth who opt out of HH and are enrolled in Medicaid Managed Care, the MMCP will monitor the POC. For children/youth who opt out of HH and are not enrolled in Medicaid Managed Care the Independent Entity will monitor the POC. C-YES will also conduct HCBS Eligibility Determinations for children/youth who are not enrolled in Medicaid at the point of referral for HCBS eligibility determination.

## Additional State Plan Behavioral Health (BH) Services

The following State Plan BH services available to children/youth under age 21 were transitioned into Medicaid Managed Care on July 1, 2019, and will follow billing procedures defined in [New York State Health and Recovery Plan \(HARP\) / Mainstream Behavioral Health Billing and Coding Manual](#):

- Assertive Community Treatment (ACT)
- Comprehensive Psychiatric Emergency Program (CPEP) (including Extended Observation Bed)
- Continuing Day Treatment (CDT) (minimum age is 18 for medical necessity for this adult-oriented service)
- OASAS Outpatient and Opioid Treatment Program (OTP) services
- OASAS Outpatient Rehabilitation Services
- OASAS Outpatient Services



- Residential Addiction Services
- Partial Hospitalization
- Personalized Recovery Oriented Services (PROS) (minimum age is 18 for medical necessity for this adult-oriented service)

This includes OMH Serious Emotional Disturbance (SED) designated clinics, which were previously carved out of MMC for children/youth with SED diagnoses.

## Services Included in or Excluded from Capitation Payments to Medicaid Managed Care Plans

The six CFTSS and the Behavioral Health State Plan services for enrollees under 21 are at-risk for MMCP and are included in the capitation rate.

The MMCP capitation payment will not include Children's HCBS and MMCPs will not be at-risk for Children's HCBS until September 30<sup>th</sup>, 2023. NYS DOH will confirm this date in writing. MMCPs will be reimbursed on a FFS basis outside the capitation rate by submitting claims for Children's HCBS to NYS under supplemental rate codes.

The rate code/CPT code/modifier code combinations for all the services described in this document are shown in Appendix B: Children's HCBS Coding Table.

## Fundamental Requirements

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### Provider Designation to Deliver Services

Providers of the following services are required to receive a designation from NYS to provide and be reimbursed for CFTSS and Children’s HCBS. CFTSS may require additional licensure, certification, or approvals from State agencies based on the population(s) served.

#### Children and Family Treatment and Support Services (CFTSS):

- Community Psychiatric Support and Treatment (CPST)
- Crisis Intervention (CI)
- Family Peer Support Services (FPSS)
- Other Licensed Practitioners (OLP)
- Psychosocial Rehabilitation (PSR)
- Youth Peer Support (YPS)

#### Children’s Home and Community Based Services (HCBS):

- Adaptive and Assistive Technology
- Caregiver/Family Advocacy and Support Services<sup>5</sup>
- Community Habilitation
- Day Habilitation
- Environmental Modifications
- Non-Medical Transportation<sup>6</sup>
- Palliative Care Counseling and Support Services
- Palliative Care Expressive Therapy
- Palliative Care Massage Therapy
- Palliative Care Pain & Symptom Management
- Prevocational Services
- Respite (Planned & Crisis)
- Supported Employment
- Vehicle Modifications

For more information on qualifications required for provider designation, refer to the Children’s [HCBS Manual](#) and the [CFTSS Manual](#).

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<sup>5</sup> This is a consolidation of the previous services for “Caregiver Family Support and Services” and “Community Advocacy Training and Supports.”

<sup>6</sup> Non-Medical Transportation will be paid Fee-for-Service for eligible children/youth, regardless of whether the child/youth is enrolled in Medicaid Managed Care, to leverage the existing [Medicaid Fee-for-Service transportation infrastructure](#).

## Services that do not require State Designation

The following services do not require State designation; these will be coordinated between the Care Management agency/C-YES, LDSS/MMCP, and NYS DOH.

- Adaptive and Assistive Technology (AT)
- Environmental Modifications (EMods)
- Vehicle Modifications (VMods)

## Medicaid-Enrolled Provider

To be paid for delivering a Medicaid service, all providers eligible to enroll in Medicaid are required to enroll in Medicaid. Information on how to become a Medicaid provider is available on the eMedNY website: <https://www.emedny.org>.

Additional information specific to Medicaid provider enrollment for children/youth's services is available at the following link: <https://ctacny.org/training/medicaid-provider-enrollment-new-childrens-spa-and-hcbs-providers>.

Memo on Medicaid Provider Enrollment for Individual Practitioners and Designated Agencies:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/provider\\_enrollment\\_npi\\_memo.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/provider_enrollment_npi_memo.pdf)

MCTAC webinar: <https://ctacny.org/training/medicaid-provider-enrollment-new-childrens-spa-and-hcbs-providers>

## Medicaid Managed Care Plan Contracting

To be paid for services delivered to a child/youth enrolled in a Medicaid Managed Care Plan, a provider must be contracted and credentialed with that MMCP for the service rendered (i.e. in the MMCP's network).

A MMCP has discretion to deny a claim from an out of network provider:

- Exception: For any of the newly carved-in services, if a provider is delivering a service to the enrollee prior to the implementation date and does not contract with the MMCP, the MMCP must allow a provider to continue to treat an enrollee on an out of network basis for up to 24 months following the implementation date.
- Single Case Agreements (SCA) may be executed between a MMCP and a provider when an out of network provider has been approved by a MMCP to deliver specific services to a specific MMCP enrollee. MMCPs must execute SCAs with non-participating providers to meet clinical needs of children/youth when in-network services are not available. The MMCP must pay at least the NYS government rates

for 24 months from the service implementation date.

MMCPs are held to specific network requirements for services described in this manual. NYS monitors MMCP contracting regularly to ensure network requirements are met.

## Rates

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### Government Rates

NYS law requires that MMCPs pay government rates (otherwise known as Medicaid fee-for-service rates) for certain services administered by a MMCP.

Upon the transition date of the respective services, MMCPs will be required to pay government rates for at least 24 months or as long as governed by State law. This applies to the following services:

- BH services covered by Medicaid Managed Care
- Children's CFTSS
- Children's HCBS

### Productivity Adjustment

HCBS and CFTSS rates are subject to change based on factors such as budget adjustments, Waiver amendments, Federal regulation, and other similar external events. Any temporary rate adjustments for the budget year will be reflected in the HCBS and CFTSS rate chart which is located here:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/2022-04-01\\_bh\\_kids\\_hcbs\\_rate\\_summary.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2022-04-01_bh_kids_hcbs_rate_summary.pdf)

### Regions

Regions are assigned to providers based upon the geographic location of the provider's headquarters, and are defined by the Department of Health as follows:

- *Downstate*: 5 boroughs of New York City, counties of Nassau, Suffolk, Westchester, Rockland, Putnam, Orange, Dutchess, Sullivan and Ulster
- *Upstate*: Rest of State

## Claims

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### General Claim Requirements<sup>7</sup>

Electronic claims will be submitted using the 837i claim form to both Medicaid FFS and MMCPs. Paper claims (UB-04) and web-based claiming will also be accepted by MMCPs. For Medicaid Managed Care billing for E-Mods, V-Mods, and AT, please refer to applicable guidance in this manual.

Each service has a unique rate code. If a child/youth receives multiple services in the same day with the same CPT code, but separate rate codes and modifiers, all services would be payable.

### Enrollment Status

*Before delivering services* to a child/youth, providers are responsible for checking the Electronic Provider Assisted Claim Entry System (ePaces)<sup>8</sup> to verify the child/youth's:

- Medicaid enrollment status
- HCBS eligibility status – both Level of Care (LOC) and active, correct k-code (before delivering HCBS)
- MMCP enrollment status

Claims will not be paid if a claim is submitted for a child/youth who is not enrolled with Medicaid, a child/youth not eligible for HCBS, or if the claim was submitted to an incorrect MMCP.

### Medicaid Fee-For-Service Claiming (eMedNY)

Claims for services delivered to a child/youth in receipt of fee-for-service Medicaid are submitted by providers to eMedNY. See <https://www.emedny.org> for training on use of the eMedNY system. Claim submissions need to adhere to the 90-day timely filing rules for Medicaid FFS. See NYS Medicaid timely billing guidance [here](#).

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<sup>7</sup> Note: NYS will be reviewing claim and encounter data periodically and annually, or upon information that there has been fraud or abuse, to determine if inappropriate HCBS and Children and Family Treatment and Support Service combinations were provided/allowed. In instances where such combinations are discovered, NYS will make the appropriate recoveries and referrals for judicial action.

<sup>8</sup> ePaces is a web-based application which will allow Providers to create/submit claims and other transactions in HIPAA format.

## Medicaid Managed Care Plan Claiming

MMCPs and providers must adhere to the rules in this billing and coding manual.

The MMCP shall support both paper and electronic submission of claims for all claim types. The MMCP shall offer its providers an electronic payment option including a web-based claim submission system. MMCPs rely on CPT codes and modifiers when processing claims. **Therefore, all MMCPs will require claims to be submitted with the CPT code and modifier (if applicable), in addition to the NYS assigned rate code.**

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in "24" followed immediately with the appropriate four-digit rate code. This is the standard mechanism historically and currently used in Medicaid FFS billing.<sup>9</sup>

NYS will give MMCPs a complete listing of all existing providers and the rate codes they bill under, as well as the rate amounts by MMIS provider ID, locator code and/or NPI and zip+4. This list will also be posted on the OMH and OASAS websites. Billing requirements depend on the type of service provided; however, every claim submitted will require at least the following:

- Use of the 837i (electronic) or UB-04 (paper) claim format
- Medicaid fee-for-service rate code
- Valid CPT code(s)
- CPT code modifiers (as needed)
- Units of service
- Revenue codes

Sample institutional claim form can be found through MCTAC/CTAC:  
<http://billing.ctacny.org/>

MMCPs will not pay claims if submitted without the applicable rate code, CPT code, and modifiers. If an individual service has multiple modifiers listed, they must all be included on the claim submission.

Providers must adhere to timely filing guidelines as outlined in their contract with the MMCP. When a clean claim is received by the MMCP they must adjudicate per prompt pay regulations.

If a provider does not have a contract or a Single Case Agreement in place with the MMCP, the claim can be denied.

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<sup>9</sup> Attention MMCPs- This field serves a dual purpose and is already used by MMCPs to report the weight of a low birth weight baby.

## Multiple Services Provided on the Same Date to the Same Child/Youth

In some cases, a child/youth can receive multiple services on the same day. This can include multiple services within the same providers type (e.g., an evaluation and a family counseling session or an individual session and group session), or services provided by separate providers (e.g., OLP and Family Peer Support). If these services are allowed per the service combination grid in this manual, they would both be reimbursable when billed using the appropriate rate code and CPT code.

## Services Provided While in Transit

Services that are delivered in transit are allowable and may be billed within the daily limits of the service.

For example, a Family Peer Advocate escorts a family to a destination where the family will implement a strategy supported by the Family Peer Advocate; while in route, the Family Peer Advocate talks through the plan to help prepare the family. The time spent in transit would be considered part of the billable service. Transportation is not reimbursable.

## Submitting Claims for Services When the Child/Youth is Not Present

Services delivered on behalf of a child/youth to collateral contacts (family members, caregivers, and other stakeholders identified on the child/youth's plan of care) without the child/youth present are allowable and may be billed within the daily limits, if the service description includes interaction with collateral contacts.

Such services may include sharing techniques and information so the collateral can better respond to the needs of the child/youth, meetings with employers or prospective employers regarding the child/youth's needs, or education and training for family members/caregivers.

For example, a child/youth receives Day Habilitation services on Mondays and Wednesdays and is employed at a movie theatre on Tuesdays, Thursdays, and Fridays. The job coach has a 30-minute meeting with the supervisor at the movie theatre on a Monday to discuss new job responsibilities for the child/youth. The service provider may bill for Supported Employment services for the 30-minutes, even though the child/youth was not present when the service was delivered and even though the child/youth was receiving another service (Day Habilitation) at the time that Supported Employment was delivered on the child/youth's behalf, this is not considered double billing because the child/youth is receiving two separate services.



## Services Delivered by Multiple Staff Members

If two practitioners are required to deliver a service to a child/youth and family members/resources on the same date and at the same time, the provider must delineate what service and what goals each practitioner is addressing directly with the child/youth and on behalf of the child/youth in the child/youth's progress notes. The claim should reflect the time spent for each practitioner in a single claim.

Example: Practitioner A meets with the child/youth directly to deliver Caregiver/Family Advocacy and Support Services from 10:00 am to 10:30 am and Practitioner B meets with a family member/resource to deliver Caregiver/Family Advocacy and Support Services addressing a need on the behalf of the child/youth from 10:00 am to 10:30 am. The combined claim would reflect the 60-minute combined duration of the service.

Children's HCBS participants cannot receive the same HCBS from multiple designated provider agencies (e.g., participant cannot receive Planned Respite from both Provider Agency A and Provider Agency B). If extenuating circumstances necessitate the provision of the same HCBS from different providers, the HHCM/C-YES must provide documented justification for these scenarios and receive approval from the State.

## Submitting Claims for Non-Sequential Time for the Same Service, on the Same Day

If the same service is delivered to the same child/youth on the same day but at non-sequential times, the total time spent on the service may be submitted as a combined claim.

For example, from 10:00am to 10:15am, a job developer meets with a potential employer about hiring a child/youth receiving supported employment services. If, later in the same day, provider staff meet with the child/youth and their family from 1:15 pm to 1:45 pm to discuss the potential new job, the service provider would document the multiple services provided during the day and bill for a combined time of 45 minutes (3 units) at the individual fee.

## Timed Units per Encounter of Service

Timed Units per Encounter of Service		
Range of Minutes per Face-to-Face Encounter	Billable Minutes	Billable Units (15 Minutes per Unit)
Under 8 minutes	1-7 minutes	Not billable
8-22 minutes	15 minutes	1 unit
23-37 minutes	30 minutes	2 units
38-52 minutes	45 minutes	3 units
53-67 minutes	60 minutes	4 units
68-82 minutes	75 minutes	5 units
83-97 minutes	90 minutes	6 units
98-112 minutes	105 minutes	7 units
113-127 minutes	120 minutes	8 units

## Submitting Claims for Daily Billed Services

Services that are billed on a daily basis should be submitted on separate claims.

## Claims Coding Table

Appendices A and B show the rate code, CPT code, and modifier code combinations that are required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth’s service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

## Claims Testing

To facilitate a smooth transition to Medicaid Managed Care billing, the MMCPs will reach out and offer billing/claim submission training to newly contracted providers and providers in active negotiation to contract. This will include testing claims submission and processing, and issuance of MMCP contact and support information to assist programs in claim submission.

**Providers are expected to test the claims submission process with MMCPs for all delivered services prior to the service implementation date and upon executing a new contract. This should begin no later than 90 days prior to the implementation date.**

# Claiming Information for Medicaid EPSDT Children and Family Treatment and Support Services and Children’s Home and Community Based Services

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## Service Combinations

Only certain combinations of Children’s HCBS and State Plan services are allowed by Medicaid within a child/youth’s current treatment plan. The grid below shows the allowable service combinations.

When determining which service should be utilized, MMCPs, providers, families, and care managers should discuss which services best meet the individual needs of the child/youth.

**New York State Children’s Health and Behavioral Health Services Billing and Coding Manual**

<b>NYS Allowable Billing Combinations of Children’s Behavioral Health, Children and Family Treatment and Support Services and HCBS</b>												
<b>HCBS/State Plan Services</b>	<b>OMH Clinic</b>	<b>OASAS Clinic</b>	<b>OASAS Opioid Treatment Program</b>	<b>OMH Youth ACT</b>	<b>OMH PROS*</b>	<b>OMH CDT*</b>	<b>OMH Partial Hospital</b>	<b>OASAS Outpatient Rehab</b>	<b>CPST/ OLP</b>	<b>PSR</b>	<b>FPSS</b>	<b>YPST</b>
<b>Day Habilitation</b>	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Community Habilitation</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Caregiver/Family Advocacy and Support Services</b>	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Respite</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Prevocational Services</b>	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Supported Employment</b>	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Other Licensed Practitioner (OLP)</b>	Yes**	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
<b>Community Psychiatric Supports and Treatment (CPST)</b>	Yes	Yes	Yes	No	No	No	Yes	Yes	-	Yes	Yes	Yes
<b>Psychosocial Rehabilitation (PSR)</b>	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	-	Yes	Yes

\*These services available to youth aged 18 and older

\*\*OMH guidance is forthcoming to avoid duplication in services.

**NYS Allowable Billing Combinations of Children’s Behavioral Health, Children and Family Treatment and Support Services and HCBS**

HCBS/State Plan Services	OMH Clinic	OASAS Clinic	OASAS Opioid Treatment Program	OMH Youth ACT	OMH PROS*	OMH CDT*	OMH Partial Hospital	OASAS Outpatient Rehab	CPST/OLP	PSR	FPSS	YPST
Youth Peer Support and Training	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-
Family Peer Support	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-
Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Palliative Care Pain & Symptom Management	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Palliative Care Counseling and Support Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Palliative Care Massage Therapy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Palliative Care Expressive Therapy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Accessibility Modifications	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adaptive and Assistive Technology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

\* These services available to youth aged 18 and older

## Provider Assistance

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MMCPs are required to develop and implement provider training and support programs for network providers. This training and support will allow network providers to gain the appropriate knowledge, skills, and expertise, and receive technical assistance to comply with the MMCPs' requirements. Training and technical assistance shall be provided to network providers on billing/claims submission, coding, data interface, documentation requirements, and UM requirements.

Network providers shall be informed in writing regarding the information requirements for UM decision making, procedure coding and submitting claims. MMCPs will provide technical assistance in other areas such as claim submission as indicated by provider performance identified through the quality management and provider profiling programs put in place by the MMCP. MMCPs will ensure providers receive prompt resolution to their inquiries.

## Where to Submit Questions and Complaints

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Questions and complaints related to billing, payment, or claims should be directed as follows:

Regarding HCBS or the Children's Health and Behavioral Health System Transformation generally: [BH.Transition@health.ny.gov](mailto:BH.Transition@health.ny.gov)

Specific to Medicaid Managed Care and for any type of provider/service: [Managedcarecomplaint@health.ny.gov](mailto:Managedcarecomplaint@health.ny.gov)

Specific to a mental health provider/service: [OMH-Managed-Care@omh.ny.gov](mailto:OMH-Managed-Care@omh.ny.gov)

Specific to a substance use disorder provider/service: [PICM@oasas.ny.gov](mailto:PICM@oasas.ny.gov)

Specific to an OPWDD provider/service: [Central.Operations@opwdd.ny.gov](mailto:Central.Operations@opwdd.ny.gov)



## Children and Family Treatment and Support Services (CFTSS)<sup>10</sup>

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Additional information on the CFTSS Medicaid State Plan Services can be found in the [Medicaid State Plan Children and Family Treatment and Support Services Provider Manual for Children’s BH Early and Periodic Screening and Diagnostic Treatment \(EPSDT\) Services](#).

### CFTSS Off-Site:

The off-site rate compensates provider agencies for staff travel costs directly related to service provision. The off-site rate must only be used when services are delivered off-site (community location; the off-site rate cannot be used when services are delivered at an agency designated/licensed site) and can only be reimbursed in conjunction with a completed CFTSS service claim. Only one off-site rate can be billed per service, per claim.

The off-site rate cannot be reimbursed for situations when providers travel off-site but a service was not delivered. If multiple staff travel to provide different services by each staff, the off-site rate can be reimbursed per service. When multiple service sessions occur at the same community location (e.g., school, library, community center, etc.) for multiple children/families, the off-site rate should only be billed for one session/identified child unless sessions were separated by travel.

## Other Licensed Practitioner (OLP)

OLP consists of three different service components. These services, which are described in detail below are:

- Evaluation
- Counseling
- Crisis

OLP is a term that refers to *non-physician licensed behavioral health practitioners* (“NP-LBHPs”). NP-LBHPs authorized under OLP include the following:

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<sup>10</sup> Subject to additions

- Licensed Psychoanalysts
- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists
- Licensed Mental Health Counselors
- Licensed Masters Social Workers when under the supervision of Licensed Clinical Social Workers (LCSWs), Licensed Psychologists, or Psychiatrists
- Licensed Creative Arts Therapist

NP-LBHPs are licensed clinicians able to practice independently for which reimbursement is authorized under OLP within the Medicaid State Plan. This OLP “billing authority” allows services provided by NP-LBHPs to be reimbursable when delivered off-site in nontraditional settings, including the home, community, or other site-based settings when appropriate, as permissible under State practice law. Services must be within the practitioner’s scope of practice, as defined in NY State law.

When submitting claims for any of the OLP services the following rules apply:

### OLP – Licensed Evaluation

Licensed Evaluation (Assessment) is the process of identifying a child/youth’s strengths and weaknesses, problems and service needs, through a comprehensive evaluation of the child/youth’s current mental, physical, and behavioral condition and history. The assessment is the basis for establishing a behavioral health diagnosis where needed, and treatment plan that is conducted within the context of the child/youth self-identified needs, goals, and ethnic, religious and cultural identities. In instances where a diagnosis is not yet known and/or not specified, providers can use an unspecified ICD-10 diagnosis code, such as R69 (illness, unspecified), F99 (mental disorder, not otherwise specified), or an appropriate Z-code. Appendix C contains a listing of z-codes that may be appropriate to use in such instances; please note that this list is not intended to be exhaustive of all z-codes that could potentially be used.

- Claims for OLP initial evaluation are defined using a distinct rate code (see Appendix A).
- Off-site services will be billed with one claim for the service rate code and a second claim for the off-site rate code. These would both have the same procedure code and different modifiers (as described in Appendix A).
- Claims are billed daily, in 15-minute units.
- Assessments may be provided on-site or off-site (Off-site delivered in a community-based location other than the agency’s designated address).
- Each claim must include the appropriate procedure code and modifier as noted in the rate table.
- Off-site is billed daily in 15-minute units.

**Note:** There are no daily or annual claim limits associated with any of the evaluation services listed above. All determinations of scope, frequency, and duration must be in accordance with medical necessity and an individualized treatment plan.

## OLP – Counseling

Psychotherapy (Counseling) is the therapeutic communication and interaction for the purpose of alleviating symptoms or functional limitations associated with a child/youth’s behavioral health needs, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the child/youth’s capacity to achieve age–appropriate developmental milestones.

### OLP - Individual and/or Family Counseling

- Claims for OLP individual and/or family counseling services are defined using a distinct rate code. This service may be provided to the child/youth and/or to the child/youth’s family (with or without the child/youth present). See Appendix A for the list of rate codes and descriptions.
- Claims are billed daily, in 15-minute units. If a child/youth counseling service and family counseling service are provided on the same day, each service must be listed on the claim using the appropriate CPT/modifier combination.
- Each counseling claim must include the CPT code.
- Counseling claims must also include the appropriate modifier(s) in addition to CPT code.
- A separate claim is submitted for off-site.
- Off-site is billed daily, in 15-minute units.
- NOTE: When submitting a fee-for-service claim for both child/youth and family counseling occurring on the same day, the provider must include both services on one claim line with all appropriate modifiers and combined service units (e.g., rate code 7901, CPT code – H0004, modifiers EP, HS, 8 units – indicates a child/youth counseling session AND a family counseling session without the child/youth, for combined total units of 8). Medicaid managed care claims for Individual and Family Counseling will continue to be submitted using two separate claim lines.

### OLP – Group Counseling

- OLP group services are claimed using a distinct rate code. See Appendix A for the list of rate codes and descriptions.
- Group sessions are billed daily, with a separate claim for each member in the group, in 15-minute units.
- Each group counseling claim must include the CPT code and modifier(s).
- Group size may not exceed more than eight members.
- Group sessions may be provided on-site or off-site.

- When group sessions are provided off-site, each member of the group bills using two claims: the first using the service rate code and the second using the off-site group add-on rate code.
- Off-site is billed daily in 15-minute units.

**Note:** There are no daily or annual claim limits associated with any of the counseling services listed above. All determinations of scope, frequency, and duration must be in accordance with medical necessity and an individualized treatment plan.

## Crisis Under OLP

**Note:** The three crisis services described below are NOT part of the separate Crisis Intervention State Plan service described later in this manual. Any child/youth receiving this service must have already been evaluated and under the care of the practitioner delivering the OLP (counseling and evaluated) prior to using the crisis components.

Crisis under OLP is used if the child/youth experiences psychiatric, behavioral, or situational distress in which the NP-LBHP is contacted as the treatment provider. The reimbursement categories of Crisis Triage (By telephone), Crisis Off-Site (In-person) and Crisis Complex Care (Follow up) allow the NB-LBHP to provide the necessary interventions in crisis circumstances.

### OLP - Crisis Off-site

- Claims are billed daily, in 15-minute units.
- Each crisis claim must include the appropriate CPT code and modifier(s).
- May only be provided off-site.
- Only one claim is submitted for OLP Crisis; a separate off-site claim is not permissible.

### OLP - Crisis Triage (by telephone)

- Claims are billed daily, in 15-minute units.
- Each crisis claim must include the appropriate CPT code and modifier(s).

### OLP - Crisis Complex Care (follow-up to Crisis)

- Claims are billed daily, in five-minute units.
- Each Crisis Complex Care claim must include the appropriate CPT code and modifier(s).
- Crisis Complex Care is provided by telephone.

**Note:** There are no daily or annual claim limits associated with any of the crisis services listed above.

## Community Psychiatric Support and Treatment (CPST)

CPST services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the child/youth's treatment plan. This includes the implementation of interventions using Rehabilitative Psychoeducation, Intensive Interventions, Strength-based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Term Crisis Management.

Claims for CPST services are defined based on child/youth and/or family and collateral (with or without the child/youth present) or group and where the service is provided (i.e., on-site or off-site). See Appendix A for the list of rate codes and descriptions.

When submitting claims for CPST services the following rules apply:

### CPST - Service Professional – Individual and/or Family

- CPST claims require the use of the appropriate rate code (see Appendix A).
- CPST services are billed daily, in 15-minute units. If a child/youth CPST service and family CPST service are provided on the same day, each service must be listed on the claim using the appropriate CPT/modifier combination.
- Each CPST claim must include the CPT code and modifier(s).
- CPST may be provided on-site or off-site.
- Off-site CPST claims will be billed with one claim for the service rate code and a second claim for the off-site rate code.
- Off-site CPST is billed daily in 15-minute units.

### CPST - Service Professional - Group

- Requires the use of the appropriate rate code (see Appendix A).
- CPST group services are billed daily, in 15-minute units.
- Each CPST group claim must include the CPT code and modifier(s).
- Group size may not exceed more than eight members.
- CPST group sessions may be provided on-site or off-site.
- When group sessions are provided off-site, each member of the group bills using two claims: the first using the service rate code and the second using the off-site group add-on rate code.
- Off-site CPST is billed daily in 15-minute units.

**Note:** There are no daily or annual claim limits associated with any of the CPST services listed above. All determinations of scope, frequency, and duration must be in accordance with medical necessity and an individualized treatment plan.

## Psychosocial Rehabilitation (PSR)

Psychosocial Rehabilitation (PSR) services are designed to restore, rehabilitate, and support a child/youth's developmentally appropriate functioning. Services assist with implementing interventions on a treatment plan to compensate for, or eliminate, functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth's behavioral health needs.

PSR is divided into two different types of sessions: Individual and Group. Claims for PSR services are defined using distinct rate codes based on the type of service provided (i.e., individual or group). See Appendix A for the list of rate codes and descriptions.

When submitting claims for PSR services the following rules apply:

### PSR - Service Professional - Individual

- Requires the use of the appropriate rate code (see Appendix A).
- PSR individual services are billed daily in 15-minute units.
- Each PSR claim must include the appropriate CPT code and modifier(s).
- PSR may be provided on-site or off-site.
- Off-site PSR is billed using two claims: the first using the service rate code and the second using the off-site add-on rate code. Both will include the same procedure code and different modifiers (see Appendix A).
- Off-site PSR is billed daily in 15-minute units.

### PSR - Service Professional – Group

- PSR Group services are billed daily, in 15-minute units.
- Each PSR Group claim must include the CPT code and modifier(s).
- Group size may not exceed more than eight members.
- PSR Group sessions may be provided on-site or off-site.
- When group sessions are provided off-site, each member of the group bills using two claims: the first using the service rate code and the second using the off-site group add-on rate code.
- Off-site PSR is billed daily in 15-minute units.

**Note:** There are no daily or annual claim limits associated with any of the PSR services listed above. All determinations of scope, frequency, and duration must be in accordance with medical necessity and an individualized treatment plan.

## Family Peer Support Services (FPSS)

FPSS services are an array of formal and informal services and supports provided to families caring for/raising a child/youth who is experiencing social, emotional, developmental, medical, substance use, and/or behavioral challenges in their home,

school, placement, and/or community. FPSS services provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth (with or without the child/youth present).

FPSS is divided into two different types of sessions: Individual and Group. Services can be provided on-site or off-site. See Appendix A for the list of rate codes and descriptions.

When submitting claims for FPSS services the following rules apply:

### FPSS Service Professional - Individual

- Requires the use of the appropriate rate code (see Appendix A).
- FPSS services are billed daily, in 15-minute units.
- Each FPSS claim must include the CPT code and modifier(s).
- FPSS may be provided on-site or off-site.
- Off-site FPSS billed using two claims: the first using the service rate code and the second using the off-site add-on rate code.
- Off-site FPSS is billed daily in 15-minute units.

### FPSS Service Professional - Group

- Requires the use of the appropriate rate code (see Appendix A).
- FPSS group services are billed daily, in 15-minute units.
- Each FPSS group claim must include the CPT code and modifier(s).
- Group size may not exceed more than 12 members.
- FPSS group sessions may be provided on-site or off-site.
- When group sessions are provided off-site, each member of the group bills using two claims: the first using the service rate code and the second using the off-site group add-on rate code.
- Off-site FPSS is billed daily in 15-minute units.

**Note:** There are no daily or annual claim limits associated with any of the FPS services listed above. All determinations of scope, frequency, and duration must be in accordance with medical necessity and an individualized treatment plan.

## Youth Peer Support (YPS)

Youth Peer Support (YPS) services are formal and informal services and supports provided to children/youth who are experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community-centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of



skills learned throughout the treatment processes.

YPS is divided into two different types of sessions: Individual and Group. Claims for YPS services are defined using distinct rate codes based on the type of service provided (i.e., individual or group.). See Appendix A for the list of rate codes and descriptions.

When submitting claims for YPS services the following rules apply:

### YPS Service Professional - Individual

- YPS claims require the use of the appropriate rate code (see Appendix A).
- YPS services are billed daily, in 15-minute units.
- Each YPS claim must include the CPT code and modifier(s).
- Services provided by a bachelor's level practitioner must include the modifier.
- YPS may be provided on-site or off-site.
- Off-site YPS billed using two claims: the first using the service rate code and the second using the off-site add-on rate code.
- Off-site is billed daily in 15-minute units.

### YPS Service Professional - Group

- YPS claims require the use of the appropriate rate code (see Appendix A).
- YPS group services are billed daily, in 15-minute units.
- Each YPS group claim must include the CPT code and modifier(s).
- Group size may not exceed more than eight members.
- YPS group sessions may be provided on-site or off-site.
- When group sessions are provided off-site, each member of the group bills using two claims: the first using the service rate code and the second using the off-site group add-on rate code.
- Off-site is billed daily in 15-minute units.

**Note:** There are no daily or annual claim limits associated with any of the YPS services listed above. All determinations of scope, frequency, and duration must be in accordance with medical necessity and an individualized treatment plan.

## Crisis Intervention

All children/youth who are identified as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress, and which exceeds the abilities and the resources of those involved (e.g., collateral, provider, community member) to effectively resolve it are eligible for Crisis Intervention.

Crisis Intervention components and distinct rate code descriptions:

- Mobile Crisis



- One Person Response: Licensed
- Two Person Response: Licensed/Unlicensed/Certified Peer
- Two Person Response: Both Licensed (up to 90 minutes)
- Two Person Response: Both Licensed (90-180 minutes)
- Two Person Response: Both Licensed (over 180 minutes)
- Two Person Response: Licensed/Unlicensed/Certified Peer (90-180 minutes)
- Two Person Response: Licensed/Unlicensed/Certified Peer (over 180 minutes)
  
- Mobile and Telephonic Follow up
  - One Person Face-to-Face Follow-Up: Licensed
  - One Person Face-to-Face Follow-Up: Unlicensed/Certified Peer
  - One Person Face-to-Face Follow-Up: Licensed/Unlicensed/Certified Peer
  - Telephonic Follow-Up: Licensed
  - Telephonic Follow-Up: Unlicensed/Certified Peer

Claims for Crisis Intervention services are defined using distinct rate codes. See Appendix A for the list of rate codes and descriptions.

When submitting claims for Crisis Intervention services the following rules apply:

### Crisis Intervention – One Licensed

- Crisis Intervention one licensed claims requires the use of the appropriate rate code (see Appendix A).
- Services are billed daily, in 15-minute units.
- Each service must include the CPT code and modifier(s).
- This service is provided off-site; a separate off-site claim is not permissible.

### Crisis Intervention – Two Person Response: Licensed and Unlicensed/Certified Peer

- Crisis Intervention with two clinicians, including one licensed requires the use of the appropriate rate code (see Appendix A).
- Services are billed daily, in 15-minute units.
- Each service must include the CPT code and modifier(s).
- This service is provided off-site; a separate off-site claim is not permissible.

### Crisis Intervention – Two Person Response: Both Licensed (up to 90 minutes)

- Crisis Intervention two licensed providers claims require the use of the appropriate rate code (see Appendix A).
- Services are billed daily, in 15-minute units.

- Each service must include the CPT code and modifier(s).
- This service is provided off-site; a separate off-site claim is not permissible.

### Crisis Intervention – Two Person Response: Both Licensed (90-180 minutes)

- Crisis Intervention exceeds 90 minutes and less than 180 minutes with two clinicians, both licensed; requires the use of the appropriate rate code (see Appendix A).
- Services are billed per diem.
- Each service must include the CPT code and modifier(s).
- Services are billed daily.
- This service is provided off-site; a separate off-site claim is not permissible.

### Crisis Intervention - Two Person Response: Both Licensed (over 180 minutes)

- Crisis Intervention Per Diem over 180 minutes, two clinicians, both licensed; requires the use of the appropriate rate code (see Appendix A).
- Services are billed per diem.
- Each service must include the CPT code and modifier(s).
- Services are billed daily.
- This service is provided off-site; a separate off-site claim is not permissible.

### Two Person Response: Licensed and Unlicensed/Certified Peer (90-180 minutes)

- Crisis Intervention over 90 minutes and less than 180 minutes with two clinicians, including one licensed; requires the use of the appropriate rate code (see Appendix A).
- Services are billed per diem.
- Each service must include the CPT code and modifier(s).
- Services are billed daily.
- This service is provided off-site; a separate off-site claim is not permissible.

### Two Person Response: Licensed and Unlicensed/Certified Peer (over 3 hours)

- Crisis Intervention Per Diem, over 180 minutes, two clinicians, including one licensed; requires the use of the appropriate rate code (see Appendix C).
- Services are billed per diem.
- Each service must include the CPT code and modifier(s).
- Services are billed daily.
- This service is provided off-site; a separate off-site claim is not permissible.

## Crisis Intervention Mobile and Telephonic Follow up

Crisis Intervention Mobile and Telephonic Follow up may be provided to the family for up to 14 days post contact/crisis occurrence. The service may include further assessment of mental health needs, coordination with collateral providers, and/or linkage to services or other collateral contacts. The end of the episode is determined by resolution and alleviation of the child/youth's acute symptoms, and/or upon transfer to the recommended level of care.

- Services are billed daily, in 15-minute units.
- Each service must include the CPT code and modifier(s).
- Mobile Follow-up is provided off site; a separate off-site claim is not permissible.
- Mobile/Telephonic can be delivered with distinct rate code descriptions for the following (found in Appendix A):
  - One Person Face-to-Face Follow-Up: Licensed
  - One Person Face-to-Face Follow-Up: Unlicensed/Certified Peer
  - One Person Face-to-Face Follow-Up: Licensed and Unlicensed/Certified Peer
  - Telephonic Follow-Up: Licensed
  - Telephonic Follow-Up: Unlicensed/Certified Peer

**Note:** There are no daily or annual claim limits associated with any of the Crisis Intervention services listed above. All determinations of scope, frequency, and duration must be in accordance with medical necessity and an individualized treatment plan.

## Children's Home and Community Based (HCBS) Services

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### Prevocational Services

Prevocational Services are individually designed to prepare a child/youth aged 14-20 to engage in paid or volunteer work or career exploration. Prevocational Services are structured around teaching concepts such as appropriate work habits, acceptable job behaviors, compliance with job requirements, attendance, task completion, problem solving, and safety based on a specific curriculum related to children/youth with disabilities. Prevocational Services are not job-specific, but rather are geared toward facilitating success in any work environment for children/youth who are not receiving other prevocational services.

HCBS Prevocational Services are divided into Individual and Group. These services are billable with distinct rate codes for:

- Prevocational Individual
- Prevocational Group of 2

- Prevocational Group of 3

The distinct rate codes can be found in Appendix B.

## Caregiver/Family Advocacy and Support Services<sup>11</sup>

Caregiver/Family Advocacy and Support Services enhance the child/youth’s ability, regardless of disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family’s ability to care for the child/youth in the home and/or community as well as, provides the child/youth, family, caregivers, and collateral contacts (family members, caregivers, and other stakeholders identified on the child/youth’s POC) with techniques and information not generally available so that they can better respond to the needs of the participant. These services are intended to assist the child/youth, family/caregiver, and collateral contacts in understanding and addressing the participant’s needs related to their disability(ies). These services can enhance the child/youth’s ability, regardless of disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family’s ability to care for the child/youth in the home and/or community.

The use of this service may appropriately be provided to prevent problems in community settings when the child/youth is experiencing difficulty.

The POC objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child/youth. Participating in community events and integrated interests/occupations are important activities for all children/youth, including those with disabilities (developmental, physical, and/or behavioral health in origin). Success in these activities is dependent not only on the child/youth, but on the people, who interact with and support the child/youth in these endeavors. Caregiver/Family Advocacy and Support services improve the child/youth’s ability to gain from the community experience and enables the child/youth’s environment to respond appropriately to the child/youth’s disability and/or healthcare issues.

Caregiver/Family Advocacy and Support Services are divided into Individual and Group services, as well as different levels based on provider qualifications. They can be delivered with or without the child/youth present. The services would be billed with distinct rates codes for:

- Caregiver/Family Advocacy and Support Services – L1 Individual
- Caregiver/Family Advocacy and Support Services – L1 Group of 2

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<sup>11</sup> This is a consolidation of the previous services for “Caregiver Family Support and Services” and “Community Advocacy Training and Supports.”

- Caregiver/Family Advocacy and Support Services – L1 Group of 3
- Caregiver/Family Advocacy and Support Services – L2 Individual
- Caregiver/Family Advocacy and Support Services – L2 Group of 2
- Caregiver/Family Advocacy and Support Services – L2 Group of 3

Distinct rate codes can be found in Appendix B.

## Supportive Employment

Supportive Employment services are individually designed to support children/youth ages 14- 20 to perform in an integrated work setting in the community through the provision of intensive ongoing support, including coping skills and other training to enable the child/youth to maintain competitive, customized, or self-employment.

Supportive Employment is billed as one service and can be delivered with or without the child/youth present.

Distinct rate codes can be found in Appendix B.

## Palliative Care Pain and Symptom Management

Palliative Care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child/youth and the family. Palliative Care is provided by a specially trained team of doctors, nurses, social workers, and other specialists who work together with a child/youth’s doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life-threatening illness and can be provided along with curative treatment.

Children/youth must meet LOC functional criteria and suffer from the symptoms and stress of chronic conditions **OR** life-threatening illnesses.

Palliative Care benefits may not duplicate Hospice or other State Plan benefits accessible to children/youth.

## Palliative Care Counseling and Support Services

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child/youth and the family. Palliative care is provided by a specially trained team of doctors, nurses, social workers, and other specialists who work together with a child/youth’s doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life-threatening illness and can be provided along with curative treatment.

Children/youth must meet LOC functional criteria and suffer from the symptoms and stress of chronic conditions **OR** life-threatening illnesses.

Palliative Care Counseling and Support Services is help for children/youth and their families to cope with grief related to the children/youth's end-of-life experience. Palliative Care Counseling and Support Services are inclusive for those children/youth in receipt of Hospice care through a Hospice provider. For additional information, please see the [Bereavement Policy](#).

## Palliative Care Massage Therapy

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child/youth and the family. Palliative care is provided by a specially trained team of doctors, nurses, social workers, and other specialists who work together with a child/youth's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life-threatening illness and can be provided along with curative treatment.

Children/youth must meet LOC functional criteria and suffer from the symptoms and stress of chronic conditions **OR** life-threatening illnesses. Palliative Care Massage Therapy works to improve muscle tone, circulation, range of motion and address physical symptoms related to a child/youth's illness.

Palliative Care Massage Therapy benefits may not duplicate Hospice or other State Plan benefits accessible to children/youth.

## Palliative Care Expressive Therapy

Palliative care services are specialized medical care services focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child/youth and family. Palliative care is provided by a specially trained team of doctors, nurses, social workers, and other specialists who work together with the child/youth's doctors. The services are appropriate at any stage of a chronic condition or life-threatening illness and can be provided in addition to curative treatment.

Children/youth must meet LOC functional criteria and suffer from the symptoms and stress of chronic conditions **OR** life-threatening illnesses.

Palliative Care Expressive Therapy (art, music, and play) helps children/youth better understand and express their reactions through creative and kinesthetic treatment.

Palliative Care Expressive Therapy benefits may not duplicate Hospice or other State Plan benefits accessible to children/youth.

Distinct rate codes for the above services, are found in Appendix B.

## Respite

HCBS Respite Services include two distinct types: Planned Respite and Crisis Respite.

Planned Respite services provide planned short-term relief for family/caregivers that are needed to enhance the family/caregiver's ability to support the child/youth's functional, mental health/substance use disorder, developmental, and/or health care issues. The service is direct care for the child/youth by staff trained to provide supervision and pro-social activities that match the child/youth's developmental stage to maintain the child/youth's health and safety. Planned Respite Services support the goals identified in the child/youth's POC. Planned Respite also includes skill development activities.

Crisis Respite is a short-term intervention strategy for children/youth and their families/caregivers that is necessary to address a child/youth's behavioral health, developmental, or medical crisis or trauma, including acutely challenging emotional or medical crisis in which the child/youth is unable to manage without intensive assistance and support. Referrals to Crisis Respite services may come from Crisis Intervention providers, emergency rooms, Local Department of Social Services (LDSS)/Local Government Unit (LGU)/Single Point of Access (SPOA), schools, self-referrals, the community, or may be part of a step-down plan from an inpatient setting.

HCBS Respite Services are divided into Planned Respite Individual and Group, and Crisis Respite<sup>12</sup>.

Planned Respite Services:

- Planned Respite – Individual (up to 6 hours)
- Planned Respite – Individual (over 6 hours up to 12 hours)
- Planned Respite – Individual (over 12 hours up to 24 hours)
- Planned Respite – Group (up to 6 hours)
- Planned Respite – Group (over 6 hours up to 12 hours)

Crisis Respite Services:

- Crisis Respite (up to 6 hours)
- Crisis Respite (over 6 hours up to 12 hours)
- Crisis Respite (over 12 hours up to 24 hours)

These services are billable with unique codes and can be found in Appendix B.

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<sup>12</sup> Subject to additions



## Day Habilitation

Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills including communication, and travel that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy, and informed choice.

Individual Day Habilitation (a one-to-one provided service with an hourly unit of service) and Group Day Habilitation services are on a regularly scheduled basis for 1 or more days per week or less frequently as specified in the child/youth's POC. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

All Day Habilitation services (Group and Individual) have the same service description and focus on enabling the child/youth to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, and/or speech therapies in the POC. In addition, Day Habilitation services may serve to reinforce skills, behaviors, and/or lessons taught in other settings.

Group and Individual Day Habilitation cannot be billed as overlapping services. Supplemental services are not available to child/youth residing in certified residential settings because the residence is paid for staffing on weekday evenings and anytime on weekends.

Any child/youth receiving HCBS under this waiver may receive this service. Service necessity criteria for this service requires that the child/youth must have a developmental delay justifying the need for the provision of Day Habilitation, but the child/youth may meet Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF)/IID or Hospital LOC.

Children/youth have a maximum daily number of services that are available to children/youth based upon their residence. Children/youth residing in certified settings are limited to a maximum of six hours of non-residential services (or its equivalent) which must commence no later than 3 pm on weekdays.

Day Habilitation services will not include funding for direct, hands-on physical therapy, occupational therapy, speech therapy, nutrition, or psychology services.

Habilitation is divided into Individual and Group services. The services would be billed with distinct rates codes for:

- Day HCBS Habilitation
- Day HCBS Habilitation Group of 2
- Day HCBS Habilitation Group of 3 Distinct rate codes can be found in Appendix B.



## Community Habilitation

Community Habilitation covers services and supports related to the child/youth's acquisition, maintenance, and enhancement of skills necessary to independently perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and/or Health-Related Tasks. Acquisition, maintenance, and enhancement are defined as:

*Acquisition* is described as the service available to a physically and mentally capable child/youth who is thought to be capable of achieving greater independence by potentially learning to perform the task for him or herself. There should be a reasonable expectation that the child/youth will acquire the skills necessary to perform that task within the authorization period.

*Maintenance* is described as the service available to prevent regression in the child/youth's skill level and to also prevent loss of skills necessary to accomplish the identified task.

*Enhancement* activities are provided to the child/youth through training and demonstration to promote growth and independence with an already acquired skill level and to support the child/youth's goal outside of the training environment.

Skill acquisition, maintenance and enhancement are face-to-face services that are determined by a functional needs assessment and must be identified in the child/youth's plan of care on an individual or group basis. These identified services will be used as a means to maximize personal independence and integration in the community, preserve functioning and prevent the likelihood of future institutional placement. For this reason, skill acquisition, maintenance and enhancement services are appropriate for children/youth who have the capacity to learn to live in the community, with or without support. Community Habilitation may be delivered in individual or group modality.

ADL, IADL Skill Acquisition, Maintenance, and Enhancement is related to assistance with functional skills training and may help a child/youth accomplish specific tasks who has difficulties with skills related to:

- Self-care
- Life safety
- Medication and health management
- Communication skills
- Mobility
- Community transportation skills
- Community integration
- Appropriate social behaviors
- Problem solving
- Money management

Services may not be duplicative of any services that may be available under Community First Choice Option:

- Community HCBS Habilitation
- Community HCBS Habilitation Group of 2
- Community HCBS Habilitation Group of 3

ADL, IADL Skill Acquisition, Maintenance, and Enhancement must be provided under the following conditions:

- The need for skills training or maintenance activities has been assessed and determined through the functional assessment process and has been authorized as part of the person-centered planning process
- The activities are for the sole benefit of the child/youth and are only provided to the child/youth receiving HCBS services or to the family/caregiver in support of the child/youth
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the child/youth has a progressive medical condition
- The activities provided are consistent with the child/youth's stated preferences and outcomes in the plan of care POC
- The activities provided are coordinated with the performance of ADLs, IADLs, and health related tasks
- Training for skill acquisition, maintenance, and enhancement activities that involve the management of behaviors must use positive enforcement techniques
- The provider is authorized to perform these services for HCBS children/youth and has met any required training, certification, and/or licensure requirements

***Some specific ADL services available for training include, but are not limited to:***

Teaching bathing/personal hygiene, dressing, eating, mobility (ambulation and transferring), and toileting.

***Some specific IADL services available for skills training include, but are***

***not limited to:*** Teaching managing finances, providing or assisting with transportation (as indicated in the POC), shopping for food/clothes/ other essentials, preparing meals, assisting with the use of the telephone and/or other communication devices, managing medications, light housekeeping, environmental maintenance such as maintaining safe egress, and laundry.

**Teaching health-related tasks** is defined as specific tasks related to the needs of a child/youth, which can be delegated or assigned by licensed health-care professionals under State law to be performed by a certified home health aide or a direct service professional. Health related tasks also include tasks that home health aides or direct service professionals can perform under applicable exemptions from the Nurse Practice

Act.

***Some specific health-related tasks available for assistance include, but are not limited to:*** Teaching the child/youth to perform simple measurements and tests, assisting with the preparation of complex modified diets, assisting with a prescribed exercise program, pouring/administering/recording medications, assisting with the use of medical equipment, supplies and devices, assisting with special skin care, assisting with a dressing change, and assisting with ostomy care.

These services can be delivered at any home or community setting. Such a setting might include the child/youth's home which may be owned or rented, and work setting. Please note that this service cannot be substituted for vocational rehabilitation services provided under the Rehabilitation Act of 1973 or other Children's HCBS. Approved settings do not include an OPWDD certified residence or day program, a social day care or health care setting in which employees of the particular setting care for or oversee the enrollee. Foster care children/youth meeting LOC may receive these services in a home or community-based setting where they reside that is not an institution. OCFS Licensed Institutions are defined in New York State Social Services Law section 427.2(f) as a facility established for the 24-hour care and maintenance of 13 or more children/youth and operated by a childcare/youth agency (Voluntary Foster Care Agency).

Only those services not reimbursable under the Community First Choice Option (CFCO) State Medicaid Plan will be reimbursable under the HCBS Waiver. Children/youth living in community residences with professional staffing may only receive this service on weekdays with a start time prior to 3 pm. For school-age children/youth, this service cannot be provided during the school day.

Time spent receiving another Medicaid service cannot be counted toward the Habilitation billable service time.

This service cannot be delivered nor billed while a child/youth is in an ineligible setting, such as in a hospital, ICF/IID, or skilled nursing facility.

If a child/youth needs assistance in the schools (educationally necessary) and a school employee will be providing the service, the service must be on the child/youth's IEP (504 plan services are not reimbursable by Medicaid) and reimbursed under the State Plan, not the HCBS waiver. If a child/youth requires medically necessary services that are best delivered in the school setting by a community provider, the service must be detailed on the POC.

These services are billable with unique codes and can be found in Appendix B.

## **Environmental Modifications**

This service provides internal and external physical adaptations to the primary residence of

the enrolled child/youth that are identified as necessary to support the health, welfare, and safety of the child/youth, or that enable the child/youth to function with greater independence in the home and without which the child/youth would require an institutional and/or more restrictive living setting. The need must be documented in the child/youth's POC.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the child/youth. Adaptations that add to the total square footage of the home's footprint are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Also excluded are pools and hot tubs and associated modifications for entering or exiting the pool or hot tub.

**Repair & Replacement of Modification:** In most instances, a specific type of Environmental Modification is a one-time benefit. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding as follows: if a child/youth moves to another home; if the current modifications are in need of repair, worn-out or unsafe; or if a child/youth wishes to spend considerable time with a non-cohabitating parent in their home and such modifications are required to ensure health and safety during these periods.

State policy places certain limitations on Environmental Modifications requested when the home/apartment is a leased space, including property owner sign-off on the modification and limitations on federal/state liability for the cost of removal/replacement/repair of items in public spaces of rental properties.

Allowable Environmental Modifications under the HCBS Waiver are limited to only those services that are not reimbursable under the Community First Choice Option (CFCO) Medicaid State Plan benefit, Medicaid State Plan under 1905(a) of the Social Security Act, or other federal/state funding streams.

The LDSS will be responsible for the authorization of Environmental Modifications (E-Mods), Vehicle Modifications (V-Mods), and Assistive Technology (AT) in accordance with the child/youth's POC and this administrative directive for all children/youth participating in the Children's Waiver.

The LDSS is responsible for authorization of these services for the child/youth until:

- The child/youth is no longer participating in the Children's Waiver, or is otherwise not eligible or in need of the services (pursuant to the POC), or
- The Children's Waiver services have been added to the MMC benefit package and the child/youth is enrolled in a MMC plan, or
- The child/youth is eligible for E-Mods, V-Mods or AT under a State Plan benefit that has been included in the MMC benefit package, and the child/youth is

enrolled in MMC

For children/youth newly enrolled in MMC, the LDSS will coordinate with the child/youth's MMC plan to share information about services authorized for him or her to facilitate a smooth transition of services, with no gaps in service delivery.

Please note: Any E-Mod, V-Mod, and/or AT approval process that began prior to April 1, 2019 will continue to be processed and paid for under the procedures in place at the time the request was initiated, even if different than stated below. Services that began prior to April 1, 2019 should not be stopped or delayed due to this transition.

Most providers of E-Mods, V-Mods, and AT will require partial payment to purchase materials, technology, and/or equipment. In addition, the evaluator/assessor invoice may have to be paid prior to completion of the modification. To address these potential barriers, the NYS DOH has established a Special Project Voucher (SPV) Fund and a process that will eliminate the need for the LDSS to front funds to non-Medicaid enrolled providers in advance of receiving Medicaid reimbursement for LDSS-authorized services.

When the LDSS requires upfront funds for an AT, E-Mod, or V-Mod service, the LDSS must submit the *Description and Cost Projection Form* with all supporting documents to the NYS DOH. NYS DOH's CFCO-Children's Prior Approval staff will process the request for SPV funds, including requesting that a check be issued to the County Treasurer at the LDSS. Please note, the check will be issued from the Office of Temporary and Disability Assistance (OTDA).

In instances where SPV funding and prior approval are requested for the same service, the requests should be submitted for processing together. If either request is not approved, the LDSS will be so notified. If additional information is needed, the disbursement may be delayed pending submission of the additional information. These forms are available at: [https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/emod\\_vmod\\_at.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/emod_vmod_at.htm)

Contracts for Environmental modifications and Vehicle modifications may not exceed \$15,000 per year without prior approval from the LDSS in conjunction with NYS DOH or the MMCP. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child/youth's needs or capabilities.

The LDSS must submit the *Description and Cost Projection Form* along with supporting documentation providing detailed project/product specifications including scope, estimated material and labor costs, and other required expenditures, as well as a justification of the request to exceed the limit. The NYS DOH will process the request and return a determination to the LDSS via the same method as the original submission.

Forms should be sent to NYS DOH via email: [EModVModAT@health.ny.gov](mailto:EModVModAT@health.ny.gov)

## Vehicle Modifications

This service provides physical adaptations to the primary vehicle of the enrolled child/youth which per the child/youth's POC are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence.

The Care Manager (for FFS enrollees) or MMCP (for managed care enrollees) secures a local contractor and/or evaluator qualified to complete the required work. In the case of vehicle modifications, modifiers are certified by the National Mobility Equipment Dealers Association (NMEDA). Activities include and are not limited to determining the need for the service, the safety of the proposed modification, its expected benefit to the child/youth, and the most cost-effective approach to fulfill the child/youth's need. Standard provisions of the NYS Finance Law and procurement policies must be followed to ensure that contractors are qualified, and that State required bidding procedures have been followed. For Vehicle Modifications, the LDSS or MMCP is the provider of record for billing purposes. Services are only billed to Medicaid or the MMCP once the contract work is verified as completed and the amount billed is equal to the contract value.

Note: This service does not duplicate other services available through the New York Medicaid State Plan. All services require prior authorization by NYS DOH if exceeding established limits.

Vehicle Modifications are limited to the primary means of transportation for the child/youth. The vehicle may be owned by the child/youth or by a family member or non-relative who provides primary, consistent, and ongoing transportation for the child/youth. All equipment and technology used for entertainment is prohibited. Other exclusions include the purchase, installation or maintenance of items such as cellular phones, global positioning/tracking devices, or other mobile communication devices; repair or replacement of modified equipment damaged or destroyed in an accident; alarm systems; auto loan payments, insurance coverage; costs related to obtaining a driver's license, title/registration, license plates, emergency road service, or rental vehicles when a vehicle modification is in process.

Repair & Replacement of modification: In most instances a specific type of Vehicle Modification is a onetime benefit to motor vehicles used by the child/youth. However, in reasonable circumstances determined and approved by the State, a second modification may be considered for funding if the current modifications are in need of repair, worn-out or unsafe. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity. In addition, when the modification must be replaced or repaired, a depreciation schedule will be used to determine the limit of the amount to be applied to the cost.

Routine Maintenance of the Vehicle: Routine maintenance and/or maintenance/service



contracts are not reimbursable under this benefit.

Allowable Vehicle Modifications under the HCBS Waiver are limited to only those services that are not reimbursable under by other federal/state funding streams.

The LDSS will be responsible for the authorization of E-Mods, V-Mods, and AT in accordance with the child/youth's POC and this administrative directive for all children/youth participating in the Children's Waiver.

The LDSS is responsible for authorization of these services for the child/youth until:

- The child/youth is no longer participating in the Children's Waiver, or is otherwise not eligible or in need of the services (pursuant to the POC)
- The Children's Waiver services have been added to the MMC benefit package and the child/youth is enrolled in a MMC plan
- The child/youth is eligible for E-Mods, V-Mods, or AT under a State Plan benefit that has been included in the MMC benefit package, and the child/youth is enrolled in MMC

For children/youth newly enrolled in MMC, the LDSS will coordinate with the child/youth's MMC plan to share information about services authorized for him or her to facilitate a smooth transition of services, with no gaps in service delivery.

Please note: Any E-Mod, V-Mod, and/or AT approval process that began prior to April 1, 2019 will continue to be processed and paid for under the procedures in place at the time the request was initiated, even if different than stated below. Services that began prior to April 1, 2019 should not be stopped or delayed due to this transition.

Most providers of E-Mods, V-Mods, and AT will require partial payment to purchase materials, technology, and/or equipment. In addition, the evaluator/assessor invoice may have to be paid prior to completion of the modification. To address these potential barriers, the NYS DOH has established a Special Project Voucher (SPV) Fund and a process that will eliminate the need for the LDSS to front funds to non-Medicaid enrolled providers in advance of receiving Medicaid reimbursement for LDSS-authorized services.

When the LDSS requires upfront funds for an AT, E-Mod, or V-Mod service, the LDSS must submit *Description and Cost Projection Form* with all supporting documents to the NYS DOH. NYS DOH staff will process the request for SPV funds, including requesting a check be issued to the County Treasurer at the LDSS. Please note, the check will be issued from the Office of Temporary and Disability Assistance (OTDA).

In instances where SPV funding and prior approval are requested for the same service, the requests should be submitted for processing together. If either request is not approved, the LDSS will be so notified. If additional information is needed, the disbursement may be delayed pending submission of the additional information.

These forms are available at:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/emod\\_vmod\\_at.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/emod_vmod_at.htm)

Contracts for Environmental modifications and Vehicle modifications may not exceed \$15,000 per year without prior approval from NYS DOH or the MMCP. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child/youth's needs or capabilities.

When a service is authorized the LDSS must submit the *Description and Cost Projection Form* along with supporting documentation providing detailed project/product specifications including scope, estimated material and labor costs, and other required expenditures, as well as a justification of the request to exceed the limit. The NYS DOH will process the request and return a determination to the LDSS via the same method as the original submission.

Forms should be sent to NYS DOH via email: [EModVModAT@health.ny.gov](mailto:EModVModAT@health.ny.gov)

## Adaptive and Assistive Technology

Adaptive and Assistive Technology includes technological aids and devices identified within the child/youth's POC that enable him/her to accomplish daily living tasks that are necessary to support the health, welfare, and safety of the child/youth.

Adaptive and Assistive Technology cannot duplicate equipment and/or technology otherwise available through the Medicaid State Plan or other federal/state funding streams.

Adaptive and Assistive Technology includes but is not limited to: direct selection communicators, alphanumeric communicators, scanning communicators, encoding communicators, speech amplifiers, electronic speech aids/devices, voice activated, light activated, motion activated and electronic devices, standing boards/frames and therapeutic equipment for the purpose of maintaining or improving the child/youth's strength, mobility or flexibility to perform activities of daily living, adaptive switches/devices, meal preparation and eating aids/devices/appliances, specially adapted locks, motorized wheelchairs, guide dogs, hearing dogs, service dogs (as defined in New York Civil Rights Law Article 47-b(4)), electronic, wireless, solar-powered or other energy powered devices that demonstrate to the satisfaction of the commissioner, or designee, that the device(s) will significantly enable the child/youth to live, work or meaningfully participate in the community with less reliance on paid staff supervision or assistance. Such devices may include observation cameras, sensors, telecommunication screens and/or telephones and/or other, telecare support services/systems that enable the child/youth to interact with remote staff to ensure health and safety. Such devices cannot be used for the purpose of surveillance, but to support the child/youth to live with greater independence, Devices to assist with



medication administration, including tele-care devices that prompt, teach or otherwise assist the child/youth, portable generators necessary to support equipment or devices needed for the health or safety of the child/youth, and stretcher stations.

Adaptive and Assistive Technology Services include: A. the evaluation of the assistive technology needs of a child/youth, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the child/youth in the customary environment of the child/youth; B. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the children/youth; C. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; D. training or technical assistance for the child/youth, or, where appropriate, the family members, guardians, advocates or authorized representatives of the child/youth; and E. training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of child/youth.

Adaptive devices are expected to be a one-time only purchase. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity and approved by the State or its designee. Ongoing monitoring associated with telecare support services or other approved systems authorized under this definition may be provided if necessary, for health and safety and documented to the satisfaction of the State or designee. The HHCM, Independent Entity (IE) or MMCP CM will ensure, that where appropriate, justification from physicians, or other specialists or clinicians has been obtained.

Warranties, repairs, or maintenance on assistive technology may be reimbursed only when they are the most cost effective and efficient means to meet the need and are not available through the Medicaid state plan at 1905(a) or third-party resources.

The LDSS will be responsible for the authorization of E-Mods, V-Mods, and AT in accordance with the child/youth's POC and this administrative directive for all children/youth participating in the Children's Waiver.

The LDSS remains responsible for authorization of these services for the child/youth until:

- The child/youth is no longer participating in the Children's Waiver, or is otherwise not eligible or in need of the services (pursuant to the POC)
- The Children's Waiver services have been added to the MMC benefit package and the child/youth is enrolled in a MMC plan
- The child/youth is eligible for E-Mods, V-Mods, or AT under a State Plan benefit that has been included in the MMC benefit package, and the child/youth is enrolled in MMC

For children/youth newly enrolled in MMC, the LDSS will coordinate with the child/youth's

MMC plan to share information about services authorized for him or her to facilitate a smooth transition of services, with no gaps in service delivery.

Please note: Any E-Mod, V-Mod, and/or AT approval process that began prior to April 1, 2019 will continue to be processed and paid for under the procedures in place at the time the request was initiated, even if different than stated below. Services that began prior to April 1, 2019 should not be stopped or delayed due to this transition.

Most providers of E-Mods, V-Mods, and AT will require partial payment to purchase materials, technology, and/or equipment. In addition, the evaluator/assessor invoice may have to be paid. To address these potential barriers, the NYS DOH has established a Special Project Voucher (SPV) Fund and a process that will eliminate the need for the LDSS to front funds to non-Medicaid enrolled providers in advance of receiving Medicaid reimbursement for LDSS-authorized services.

When the LDSS requires upfront funds for an AT, E-Mod, or V-Mod service, the LDSS must submit the *AT/EMod and VMod Description and Cost Projection Form* with all supporting documents to NYS DOH. The NYS DOH staff will process the request for SPV funds, including requesting a check be issued to the County Treasurer at the LDSS. Please note, the check will be issued from the Office of Temporary and Disability Assistance (OTDA).

In instances where SPV funding and prior approval are requested for the same service, the requests should be submitted for processing together. If either request is not approved, the LDSS will be so notified. If additional information is needed, the disbursement may be delayed pending submission of the additional information.

These forms are available at:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/emod\\_vmod\\_at.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/emod_vmod_at.htm)

Cost Limits: AT costs cannot exceed \$15,000 per year without prior approval from NYS DOH or the MMCP. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child/youth's needs or capabilities.

For Adaptive and Assistive Technology, the LDSS (for FFS enrollees) or MMCP (for managed care enrollees) is the provider of record for billing purposes using the standard bidding process. Services are only billed to Medicaid once the equipment/technology is procured and the amount billed is equal to the purchased value.

LDSS or MMCP secures a local vendor qualified to complete the required work. Activities include and are not limited to determining the need for the service, the safety of the proposed equipment/technology, its expected benefit to the child/youth, and the most cost-effective approach to fulfill the child/youth's need. Standard provisions of the NYS Finance

Law and procurement policies must be followed to ensure that vendors are qualified, and that State required bidding procedures have been followed. Services are only billed to Medicaid or the MMCP once the equipment/technology is verified as received and the amount billed is equal to the contract value.

When a service is authorized the LDSS must submit the *Description and Cost Projection Form* along with supporting documentation providing detailed project/product specifications including scope, estimated material and labor costs, and other required expenditures, as well as a justification of the request to exceed the limit. The NYS DOH will process the request and return a determination to the LDSS via the same method as the original submission.

Forms should be sent to NYS DOH via email: [EModVModAT@health.ny.gov](mailto:EModVModAT@health.ny.gov)

## **Non-Medical Transportation**

Non-Medical Transportation will be billed to Medicaid FFS. Please refer to the [Medicaid Transportation Guidelines](#) and the HCBS Provider Manual found [HERE](#) for more details.

## Health Home Care Management

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Billing guidance for Health Home services can be found [here](#).

Health Home Care Management provides person-centered, child/youth and family-driven care planning and management. Health Homes deliver person-centered planning through six core services, including comprehensive care management, care coordination, health promotion, comprehensive transitional care, child/youth and family support, referral to community and social supports and service linkages using health information technology. Any child/youth meeting Health Home eligibility criteria (two or more chronic conditions, or single qualifying condition of serious emotional disturbance, complex trauma, or HIV/AIDS) may be enrolled in Health Home. Enrollees who are eligible and enrolled in 1115 Children's HCBS are eligible for Health Home Care Management.

## **Behavioral Health (BH) State Plan Services**

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Definitions for these services can be found in the billing guidance found at <https://www.omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf>.

## Appendix A – Children and Family Treatment and Support Services Rate Code Descriptions<sup>13</sup>

Appendices A and B show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth’s service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth's access to services is based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth's record. In addition to requiring concurrent utilization review and authorization as per the *Medicaid State Plan Children and Family Treatment and Support Services Provider Manual for Children’s Behavioral Health Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services January 9, 2019* and any subsequent edits, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Note: There are no unit (i.e. annual, daily, dollar amount) limits for CFTSS. All determinations of scope, frequency and duration must be in accordance with medical necessity and an individualized treatment plan.

### Other Licensed Practitioner

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
OLP Licensed Evaluation	7900	90791	EP	15 Minutes	N/A
OLP Counseling – Individual	7901	H0004	EP	15 Minutes	N/A
OLP Counseling – Family (with or without the child/youth present)			HR – Family with child/youth HS – Family without child/youth		
OLP Crisis -Offsite (In-person only)	7902	H2011	EP, ET	15 Minutes	N/A

<sup>13</sup> Subject to additions

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
OLP Crisis Triage - - Telephone	7903	H2011	EP, GT	15 Minutes	N/A
OLP Crisis Complex Care (Follow up)	7904	90882	EP, TS	5 Minutes	N/A
OLP Counseling - Group	7905	H0004	HQ, EP	15 Minutes	N/A
Offsite – OLP Evaluation Individual or Family with child/youth present  Family without child/youth present	7920	90791 or H0004 depending on service provided	90791- EP, SC - Evaluation  H0004 -SC - Individual  H0004 – HR, SC – Family with child/youth  H0004 – HS, SC – Family without child/youth	15 Minutes	N/A
Offsite – OLP Counseling Group	7927	H0004	EP, HQ, SC	15 Minutes	N/A

## OLP Counseling (Family and Individual) Fee-for-Service billing Only

OLP Counseling if **Family AND Individual** are provided on same day, combine both services on one claim line and submit.

Service	Rate Code	Unit Measure	Unit Limit
<b>Fee-for-Service Only</b> - OLP Counseling – Two Services – Family AND Individual provided on same day – combine both services on one claim line	7901	15 Minutes	N/A

## Community Psychiatric Support and Treatment

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
CPST Service Professional – Individual and/or Family (with or without the child/youth)	7911	H0036	EP	15 Minutes	N/A
CPST Service Professional - Group	7912	H0036	EP, HQ	15 Minutes	N/A
Offsite - CPST Individual and/or Family (with or without the child/youth)	7921	H0036	EP, SC	15 Minutes	N/A
Offsite – CPST Group	7928	H0036	EP, HQ, SC	15 Minutes	N/A

## Psychosocial Rehabilitation

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
PSR Service Professional	7913	H2017	EP	15 Minutes	N/A
PSR Service Professional - Group	7914	H2017	EP, HQ	15 Minutes	N/A
Offsite - PSR Individual	7922	H2017	EP, SC	15 Minutes	N/A
Offsite – PSR Group	7929	H2017	EP, HQ, SC	15 Minutes	N/A

## Family Peer Support Services

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
FPS Service Professional	7915	H0038	EP, UK	15 Minutes	N/A
FPS Service Professional - Group	7916	H0038	EP, UK, HQ	15 Minutes	N/A
Offsite – FPS Individual	7923	H0038	EP, UK, SC	15 Minutes	N/A
Offsite – FPS Group	7930	H0038	EP, HQ, SC, UK	15 Minutes	N/A



## Youth Peer Supports

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
YPS Service Professional	7917	H0038	EP	15 Minutes	N/A
YPS Service Professional - Group	7918	H0038	EP, HQ	15 Minutes	N/A
Offsite - YPS Individual	7923	H0038	EP, SC	15 Minutes	N/A
Offsite –YPS Group	7930	H0038	EP, HQ, SC	15 Minutes	N/A

## Crisis Intervention

Mobile Crisis					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
One-Person Response: Licensed	7906	H2011	EP, HO	15 Minutes	N/A
Two-Person Response: Licensed/ Unlicensed/Certified Peer	7907	H2011	EP, HT	15 Minutes	N/A
Two-Person Response: Both Licensed (up to 90 minutes)	7908	H2011	EP	15 Minutes	N/A
Two-Person Response: Both Licensed (90-180 minutes)	7936	S9484	EP, HO	Per diem (90-180 minutes)	N/A
Two-Person Response: Both Licensed (over 180 minutes)	7937	S9485	EP, HO	Per diem greater than 180 minutes	N/A
Two-Person Response: Licensed/ Unlicensed/Certified Peer (90-180 minutes)	7909	S9484	EP	Per diem (90-180 minutes)	N/A
Two-Person Response: Licensed/ Unlicensed/Certified Peer (over 180 minutes)	7910	S9485	EP	Per diem greater than 180 minutes	N/A

Mobile Follow Up Services					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
One-Person Face-to-Face Follow-Up: Licensed	7938	H2011	TS, HO	15 minutes	N/A
One-Person Face-to-Face Follow-Up: Unlicensed/Certified Peer	7939	H2011	TS, HM, HA	15 minutes	N/A
One-Person Face-to-Face Follow-Up: Licensed/Unlicensed/Certified Peer	7940	H2011	TS, HT	15 minutes	N/A

Telephonic Follow Up Services					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Telephonic Follow-Up: Licensed	7941	H2011	TS, HO, GT	15 minutes	N/A
Telephonic Follow-Up: Unlicensed/Certified Peer	7942	H2011	TS, HM, GT	15 minutes	N/A

## Appendix B – Aligned HCBS Rate Code Descriptions<sup>14</sup>

Appendices A and B show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a children/youth’s service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth’s access to services, service utilization in excess of the "soft" unit (i.e., annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth’s record. In addition to requiring concurrent utilization review and authorization as per the *Children’s Home and Community Based Services Provider Manual July 2019* and any subsequent edits, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

### Pre-Vocational Services

Pre-Vocational Services					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Prevocational Services - Individual	8006	T2015	HA	15 Minutes	8/day
Prevocational Services - Group of 2	8007	T2015	HA, UN	15 Minutes	8/day
Prevocational Services - Group of 3	8008	T2015	HA, UP	15 Minutes	8/day

### Caregiver/Family Advocacy and Support Services

Caregiver/Family Advocacy and Support Services					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit

<sup>14</sup> Subject to additions

Caregiver/Family Advocacy and Support Services – L1 Individual	8003	H2014	UK, HA	15 minutes	24/day
Caregiver/Family Advocacy and Support Services – L1 Group of 2	8004	H2014	HA, UK, UN	15 minutes	24/day
Caregiver/Family Advocacy and Support Services – L1 Group of 3	8005	H2014	HA, UK, UP	15 minutes	24/day
Caregiver/Family Advocacy and Support Services – L2 Individual	8009	H2015	HA	15 minutes	24/day
Caregiver/Family Advocacy and Support Services – L2 Group of 2	8010	H2015	HA, UN	15 minutes	24/day
Caregiver/Family Advocacy and Support Services – L2 Group of 3	8011	H2015	HA, UP	15 minutes	24/day

### Supported Employment

Supported Employment					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Supported Employment	8015	H2023	HA	15 minutes	12/day

### Palliative Care Pain & Symptom Management

Palliative Care Pain & Symptom Management					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Palliative Care - Pain and Symptom Management	8016	99347	TJ	15 minutes	No limit, as required by child/youth’s physician order

## Palliative Care Counseling and Support Services

Palliative Care Counseling and Support Services					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Palliative Care – Counseling and Support Services	8017	90832	TJ	30 minutes	Limited to the lesser of 10 units per month or 120 units per calendar year

## Palliative Care – Bereavement Services

Palliative Care - Bereavement Counseling Services					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
<b>Upstate Codes</b>					
Bereavement Services - HH Low Acuity	7946	96156		Per assessment	1 unit/calendar year
Bereavement Services HH Medium Acuity	7947	96156		Per assessment	1 unit/calendar year
Bereavement Services - HH High Acuity	7948	96156		Per assessment	1 unit/calendar year
<b>Downstate Codes</b>					
Bereavement Services - HH Low Acuity	7949	96156		Per assessment	1 unit/calendar year
Bereavement Services - HH Low Acuity	7950	96156		Per assessment	1 unit/calendar year
Bereavement Services - HH Low Acuity	7951	96156		Per assessment	1 unit/calendar year
<b>Bereavement Assessment/Counseling</b>					
Bereavement - Assessment/Counseling	7952	96156		Bereavement Risk Assessment and up to six (6) months of Bereavement counseling	1 unit/calendar year

## Palliative Care Massage Therapy

Palliative Care Massage Therapy					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Palliative Care - Massage Therapy	8018	97124	TJ	15 minutes	72 units/year

## Palliative Care Expressive Therapy

Palliative Care Expressive Therapy					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Palliative Care - Expressive Therapy	8019	96159	TJ	15 minutes	48/year

## Respite – Planned

Respite - Planned					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Planned Respite - Individual (up to 6 hours)	8023	S5150	HA	15 minutes	24/day
Planned Respite - Individual per diem (over 6 up to 12 hours)	8024	S5151	HA	Per Diem	1/day
Planned Respite – Individual per diem (over 12 up to 24 hours)	8025	S5151	HA, HK	Per diem	1/day
Planned Respite - Group per diem (over 6 up to 12 hours)	8026	S5150	HA, HK, HQ	Per diem	1/day

Planned Respite - Group (up to 6 hours)	8027	S5150	HA, HQ	15 minutes	24/day
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## Respite – Crisis

Respite - Crisis					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Crisis Respite - (up to 6 hours)	8028	S5150	HA, ET	15 minutes	24/day
Crisis Respite - (over 6 up to 12 hours)	8029	S5151	HA, ET	Per Diem	1/day
Crisis Respite - Individual (over 12 up to 24 hours)	8030	S5151	HA, ET, HK	Per Diem	1/day

## Day Habilitation

Day Habilitation					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Day HCBS Habilitation	7933	T2020	HA	15 minutes	24/day
Day HCBS Habilitation - Group of 2	7934	T2020	HA, UN	15 minutes	24/day
Day HCBS Habilitation - Group of 3 or more	7935	T2020	HA, UP	15 minutes	24/day

## Community Habilitation

Community Habilitation					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit

Community HCBS Habilitation	8012	H2014	HA	15 minutes	24/day
Community HCBS Habilitation - Group of 2	8013	H2014	HA, UN	15 minutes	24/day
Community HCBS Habilitation – Group of 3 or 4	8014	H2014	HA, UP	15 minutes	24/day

## FFS Billing for Environmental Modifications (E-Mods), Vehicle Modifications (V-Mods), and Adaptive and Assistive Technology (AT)

The Care Manager or C-YES Coordinator will coordinate requests for E-Mods, V-Mods, and AT directly with the LDSS conjunction with DOH for children/youth not enrolled in a Managed Care Plan. Requests for these services will be managed directly with the Managed Care Plan for those children/youth enrolled in a plan. Service limits are as follows:

- Assistive Technology - \$15,000 annual calendar year limit
- Environmental Modification - \$15,000 annual calendar year limit
- Vehicle Modification - \$15,000 annual calendar year limit

In all cases, service limits are soft limits that may be exceeded due to medical necessity. If the child/youth’s needs cannot be met within the established limits, the LDSS may request to exceed the limit by proving sufficient medical justification. This justification must be submitted to NYS DOH along with the request for service packet to obtain approval of the request.

## MMC Billing for Environmental Modifications (E-Mod), Vehicle Modifications (V-Mod), and Adaptive and Assistive Technology (AT)

Environmental and Vehicle modifications are non-medical services and will need to be billed from provider to plan using invoices. Plans will need to convert these invoices into claims. Plans will use 837I encounter format when billing NYS DOH.

Adaptive and Assistive Technology will be billed using 837P by the provider and by the plan when submission of the encounter to NYS DOH.

Appendices A and B show the rate code, CPT code, and modifier code combinations that will be required under Medicaid Managed Care. Providers will use these coding



combinations to indicate to the MMCP that the claim is for a children/youth’s service and is to be paid at the government rate. The procedure and modifier code combinations must be adhered to by both provider and MMCP to ensure appropriate rate payment.

In acknowledgement of the need for checks against fraud and abuse, but to ensure a child/youth’s access to services, service utilization in excess of the "soft" unit (i.e. annual, daily, dollar amount) limits must be based on medical necessity. Documentation of the medical necessity for extended durations must be kept on file in the child/youth’s record. In addition to requiring concurrent utilization review and authorization as per the [Children’s HCBS Manual](#) and any subsequent edits, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

## Environmental Modifications

Environmental Modifications					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Environmental Modifications	8032	S5165	HA	\$1.00	\$15,000 per calendar year
Environmental Modifications	8034	S5165	HA, V1	\$10.00	\$15,000 per calendar year
Environmental Modifications	8035	S5165	HA, V2	\$100.00	\$15,000 per calendar year
Environmental Modifications	8036	S5165	HA, V3	\$1,000.00	\$15,000 per year calendar

## Vehicle Modifications

Vehicle Modifications					
Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Vehicle Modifications	8041	T2039	HA	\$1.00	\$15,000 per calendar year
Vehicle Modifications	8042	T2039	HA, V1	\$10.00	\$15,000 per calendar year
Vehicle Modifications	8043	T2039	HA, V2	\$100.00	\$15,000 per calendar year
Vehicle Modifications	8044	T2039	HA, V3	\$1,000.00	\$15,000 per calendar year

## Adaptive and Assistive Technology

Adaptive and Assistive Technology
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Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Adaptive and Assistive Technology	8037	T2028	HA	\$1.00	\$15,000 per calendar year
Adaptive and Assistive Technology	8038	T2028	HA, V1	\$10.00	\$15,000 per calendar year
Adaptive and Assistive Technology	8039	T2028	HA, V2	\$100.00	\$15,000 per calendar year
Adaptive and Assistive Technology	8040	T2028	HA, V3	\$1,000.00	\$15,000 per calendar year

## Appendix C – List of Potential Z-Codes

The following list of z-codes may be used in instances where a diagnosis is not yet known and/or not specified; please note that this list is not intended to be exhaustive of all z-codes that could potentially be used.

<b><u>Code Category</u></b>	<b><u>ICD-10 Code</u></b>	<b><u>ICD-10 Code Description</u></b>
Problems Related to Upbringing	Z62.21	Child in welfare custody (in care of non-parental family member, in foster care)
Problems Related to Upbringing	Z62.810	Personal history of physical and sexual abuse in childhood [Excludes current physical or sexual abuse]
Problems Related to Upbringing	Z62.811	Personal history of psychological abuse in childhood [Excludes current psychological abuse in childhood]
Problems Related to Upbringing	Z62.812	Personal history of neglect in childhood [Excludes current neglect]
Problems Related to Upbringing	Z62.820	Parent-biological child conflict (parent-child problem)
Problems Related to Upbringing	Z62.821	Parent-adopted child conflict
Problems Related to Upbringing	Z62.822	Parent-foster child conflict
Problems Related to Primary Support Group, including Family Circumstances	Z63.4	Disappearance and death of family member
Problems Related to Primary Support Group, including Family Circumstances	Z63.5	Disruption of family by separation and divorce
Problems Related to Primary Support Group, including Family Circumstances	Z63.72	Alcoholism and drug addiction in family
Problems Related to Primary Support Group, including Family Circumstances	Z63.8	Other specified problems related to primary support group (family discord, estrangement, high expressed emotional level within family, inadequate family support, inadequate or distorted communicated within family)
Problems Related to other Psychosocial Circumstances	Z65.4	Victim of crime and terrorism (victim of torture)
Problems Related to other Psychosocial Circumstances	Z65.5	Exposure to disaster, war, and other hostilities
Problems Related to Employment and Unemployment	Z59.5	Extreme poverty
Problems Related to Housing and Economic Circumstances	Z59.9	Problem related to housing and economic circumstances, unspecified
Problems Related to other Psychosocial Circumstances	Z65.9	Problem related to unspecified psychosocial circumstances
Problems Related to certain Psychosocial Circumstances	Z64.0	Problems related to unwanted pregnancy
Problems Related to Upbringing	Z62.898	Other specified problems related to upbringing

<b><u>Code Category</u></b>	<b><u>ICD-10 Code</u></b>	<b><u>ICD-10 Code Description</u></b>
Problems Related to Employment and Unemployment	Z56.0	Unemployment, unspecified
Problems Related to Housing and Economic Circumstances	Z69.6	Low income
Problems Related to Housing and Economic Circumstances	Z59.7	Insufficient social insurance /welfare support
Problems related to education and literacy	Z55.0	Illiteracy and low level literacy
Problems Related to Housing and Economic Circumstances	Z59.0	Homelessness
Problems Related to Housing and Economic Circumstances	Z59.1	Inadequate housing
Problems Related to Housing and Economic Circumstances	Z59.4	Lack of adequate food and safe drinking water
Problems related to social environment	Z60.3	Acculturation difficulty (problem with migration, problems with social transplantation)
Problems Related to Upbringing	Z62.0	Inadequate parental supervision and control
Problems Related to Upbringing	Z62.22	Institutional upbringing
Persons encountering health services in other circumstances	Z69.010	Encounter for mental health services for victim of parental child abuse
Persons encountering health services in other circumstances	Z69.020	Encounter for mental health services for victim of non-parental child abuse
Other problems related to primary support group	Z63.31	Absence of family member due to military deployment
Screening	Z13.40	Developmental delay screening
Screening	Z13.41	Autism screening
Screening	Z13.9	Health risk assessment screening
Screening	Z13.89	Screenings, other (social emotional)
Screening	Z13.32	Encounter for maternal depression screening