



**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 Services Billing and Coding Manual

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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's benefits to Medicaid Managed Care. These services are available to children, 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.

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)<sup>2</sup> Medicaid State Plan

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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

<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

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
- Crisis Intervention (CI) – 1/1/2020

For children 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 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's HCBS covered in the managed care benefit package will be non-risk for 24 months from the date of inclusion in the MMCP benefit package (through September 2021). The MMCP capitation payment will not include these services.

The following services are available under new concurrent waiver authorities for those children who are eligible for and enrolled in HCBS. Additional detail on these services can be found in the [Home and Community Based Services Provider Manual](#).

Information on eligibility for these services can be found in the [Transition Plan for the Children's System Transformation](#).

Children's Home and Community Based Services (HCBS) include the following services:

- Adaptive and Assistive Equipment
- Caregiver Family Supports and Services
- Community Advocacy Training and Support
- Community Habilitation
- Day Habilitation
- Environmental Modifications
- Non-Medical Transportation<sup>3</sup>
- Palliative Care Bereavement Service
- Palliative Care Expressive Therapy
- Palliative Care Massage Therapy
- Palliative Care Pain & Symptom Management

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preventive, dental, mental health, developmental, and specialty services.

- Pre-Vocational Services
- Respite (Planned & Crisis)
- Supported Employment
- Vehicle Modifications

## Health Home Care Management

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

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



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

The six new Children and Family Treatment and Support Services 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 for 24 months from the benefit transition date (through September 2021). 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 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 Equipment
- Caregiver Family Supports and Services
- Community Advocacy Training and Support
- Community Habilitation
- Day Habilitation
- Environmental Modifications

- Non-Medical Transportation<sup>3</sup>
- Palliative Care Bereavement Service
- Palliative Care Expressive Therapy
- Palliative Care Massage Therapy
- Palliative Care Pain & Symptom Management
- Pre-Vocational Services
- Respite (Planned & Crisis)
- Supported Employment
- Vehicle Modifications

## 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 the Department of Health (DOH).

- Adaptive and Assistive Equipment (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'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 enrolled in a Medicaid Managed Care Plan, a

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<sup>3</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](#).

provider must be contracted and credentialed with that MMCP for the service rendered (i.e. in the MMCP's network).

A Medicaid Managed Care Plan 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. Medicaid Managed Care Plans must execute SCAs with non-participating providers to meet clinical needs of children 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.

Medicaid Managed Care Plans 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 Medicaid Managed Care Plans 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, and
- Children's HCBS

### Productivity Adjustment

Beginning on the effective date of each respective State Plan service and ongoing for one year from that date, providers will be paid adjusted rates for the new Children and Family Treatment and Support Services. These temporary rate increases have been calculated to cover the cost to providers of hiring and training staff and having services in place, ready to accept referrals without the initial volume to cover their full costs as the system matures.

Each service will be adjusted by 25 percent for the first 6 months and by 11 percent for the second 6 months, unless otherwise determined by the State. The 2020-21 Enacted Budget extended the 11% adjustment for all services through March 31, 2022. Additional information was provided by the State in the Children's Services Rate Announcement of August 25, 2020 and can be located here:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/proposed\\_spa.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm)

## 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>4</sup>

Electronic claims will be submitted using the 837i claim form to both Medicaid FFS and Medicaid Managed Care. Paper claims (UB-04) and web-based claiming will also be accepted by MMCPs. For Medicaid Managed Care billing for EMODs, VMODS, and AT, please refer to guidance on page 61 of this manual.

Each service has a unique rate code. If an individual 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 an individual, providers should **always check ePaces** to verify the individual's:

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

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<sup>4</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.

Providers should ensure individual enrollment with Medicaid, and appropriate MMCP, through the NYS system. Claims will not be paid if a claim is submitted for an individual who is not enrolled with Medicaid, an individual is not eligible for HCBS, or the claim was submitted to an incorrect MMCP.

Providers should always verify that claims are submitted to the correct MMCP.

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

Claims for services delivered to an individual 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 billing guidance [here](#).

## 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>5</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; and
- Revenue codes

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<sup>5</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.

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.

## Multiple Services Provided on the Same Date to the Same Individual

In some cases, an individual can receive multiple services on the same day. This can include multiple services within the same program type (e.g., an evaluation and a family counseling session or an individual session and group session), or services provided by separate programs (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 an individual 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 participant, meetings with employers or prospective employers

regarding the individual's needs, or education and training for family members/caregivers.

For example, an individual 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 individual. The service provider may bill for Supported Employment services for the 30-minutes, even though the individual was not present when the service was delivered and even though the individual was receiving another service (Day Habilitation) at the time that Supported Employment was delivered on the individual's behalf, this is not considered double billing because the individual is receiving two separate services.

## Services Delivered by Multiple Staff Members

If two practitioners are required to deliver a services to a child 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 1: Practitioner A meets with the child directly to deliver Community Self-Advocacy Training and Supports from 10:00 am to 10:30 am and Practitioner B meets with a family member/resource to deliver Community Self-Advocacy and Training 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.

Example 2: Practitioner A meets with one parent to deliver Caregiver Family Supports and Services from 10:00 am to 10:30 am and Practitioner B meets with another parent separately to deliver Caregiver Family Supports and Services from 10:00 am to 10:30 am. The combined claim would reflect the 60-minute combined duration of the service.

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

If the same service is delivered to the same individual 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 an individual receiving supported employment services. If, later in the same day, provider staff meet with the individual 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

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’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 client'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 client's record. In addition to requiring concurrent utilization review and authorization as per the Children’s Home and Community Based Services Provider Manual, and any subsequent edits, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

Please refer to UM Guidance for details on annual and daily limits.



## 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 an individual’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.

**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 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 &amp; Family Support and 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>Community Self-Advocacy Training and Supports</b>	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Other Licensed Practitioner (OLP)</b>	Yes**	Yes	Yes	Yes	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 age 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 ACT	OMH PROS*	OMH CDT*	OMH Partial Hospital	OASAS Outpatient Rehab	CPST/OLP	PSR	FPSS	YPST
Youth Peer Support and Training	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-
Family Peer Support	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-
Crisis Intervention	Yes	Yes	Yes	No	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 Bereavement	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 Equipment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

\* These services available to youth age 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>6</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.](#)

### 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-LBHP’s”). NP-LBHP’s authorized under OLP include the following:

- 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-LBHP’s are licensed clinicians able to practice independently for which reimbursement is authorized under Other Licensed Practitioner within the Medicaid State Plan. This OLP “billing authority” allows services provided by NP-LBHP’s 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 an individual child/youth’s

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<sup>6</sup> Subject to additions

behavioral 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 diagnosis where needed, and treatment plan, and is conducted within the context of the child/youth self-identified needs, goals, and ethnic, religious and cultural identities.

- 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, with a limit of 36 units per calendar year.
- 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, with a limit of 36 units per calendar year.

## 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 individual and/or to the individual's family (with or without the individual present). See Appendix A for the list of rate codes and descriptions.
- Claims are billed daily, in 15-minute units, with a daily unit limit of four units (1 hour per service). If an individual counseling service and family counseling service are provided on the same day, the unit max is 8 and 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, with a daily limit of four units. If individual counseling and family counseling are provided on the same day, up to eight units may be billed if the service provision required separate travel to and from the location of service.

- NOTE: When submitting a fee-for-service claim for both individual 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 an individual counseling session AND a family counseling session without the client, 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, with a daily unit limit of four units (1 hour) per individual.
- 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 with a limit of four units per day.

## 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 consumer 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 Non-Physician Licensed Behavioral Health Practitioner (NP-LBHP) is contacted as the treatment provider. The reimbursement categories- 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, with a daily unit limit of eight units (two - hour daily maximum).
- 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, with a daily unit limit of two units (30- minute daily maximum).
- 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, with a daily unit limit of four units (20- minute daily maximum).
- 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 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'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 individual 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, with a limit of six units per day (1.5 hours). If an individual CPST service and family CPST service are provided on the same day, the unit max combined is 6 units and 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, with a limit of six units per day. If an individual CPST and family CPST service are provided on the same day, up to six units may be billed if the service provision required separate travel to and

from the location of service.

### 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, with a limit of four units per day (1 hour).
- 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, with a limit of four units per day.

### 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 with a limit of eight units per day (2-hour daily maximums).
- 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, with a limit of eight units per day.

#### PSR - Service Professional – Group

- PSR Group services are billed daily, in 15-minute units, with a limit of four units per day (1 hour).

- 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 with a limit of four units per day.

## 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 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, with a limit of eight units per day (2-hour daily maximum).
- 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 with a limit of eight units per day.

### 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, with a limit of six units per day (1.5 hours).
- 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 with a limit of six units per day.

## Youth Peer Support (YPS)

YPS services are formal and informal services and supports provided to 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, with a limit of eight units per day (2- hour daily maximum).
- 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 with a limit of eight units per day.

### 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, with a limit of six units (1.5 hours).
- 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 with a limit of six units per day.

## 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 and 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 3 hours)
  - Two Person Response: Licensed and Unlicensed/Certified Peer (90-180 minutes)
  - Two Person Response: Licensed and Unlicensed/Certified Peer (over 3 hours)
  
- Mobile and Telephonic Follow up
  - One Person Face-to-Face Follow-Up: Licensed
  - One Person Face-to-Face Follow-Up: Unlicensed/Certified Peer
  - Two-person Face-to-Face Follow-Up: Licensed and 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, with a limit of six units per day (1.5 hours).
- 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, with a limit of six units per day.
- 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 requires the use of the appropriate rate code (see Appendix A).
- Services are billed daily, in 15-minute units, with a limit of six units per day.
- 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 3 hours)

- Crisis Intervention Per Diem Three Hours, 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 exceeds 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 Three Hours, 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 linkage to services or other collateral contacts. The end of the episode is determined by resolution of the 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, with a limit of six units per day (1.5 hours).
- 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
  - Two-person Face-to-Face Follow-Up: Licensed and Unlicensed/Certified Peer
  - Telephonic Follow-Up: Licensed
  - Telephonic Follow-Up: Unlicensed/Certified Peer

## Crisis Residential Services

Additional guidance forthcoming.

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

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## Caregiver Family Support and Services

Caregiver Family Supports and Services enhance the child's ability to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child in the home and/or community. Family is broadly defined, and can include families created through birth, foster care, adoption, or a self-created unit.

Caregiver Family Support and Services is divided into individual and group services and can be delivered with or without the child/youth present.

- Caregiver Family Supports and Services Individual
- Caregiver Family Supports and Services Group of 2
- Caregiver Family Supports and Services Group of 3

Distinct rate codes can be found in Appendix B.

## Prevocational Services

Prevocational Services are individually designed to prepare a child 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 with disabilities. Prevocational Services are not job-specific, but rather are geared toward facilitating success in any work environment for children 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.

## Community Self-Advocacy Training and Support

Community Self-Advocacy Training and Support improves the child's ability to participate in and gain from the community experience and enables the child/youth's environment to respond appropriately to the child/youth's disability and/or health care issues.



Community Self-Advocacy Training and Support assists the child, family/caregiver, and other collateral contacts in understanding and addressing the child's needs related to their disability(ies), to aid the child's integration into age-appropriate activities. The use of this service may appropriately be provided to prevent problems in community settings as well as when the child/youth is experiencing difficulty. The Plan of Care objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree.

Community Self-Advocacy Training and Support is divided into individual and group services and can be delivered with or without the child/youth present. The services would be billed with distinct rates codes for:

- Community Advocacy and Support Individual
- Community Advocacy and Support Group of 2
- Community Advocacy and Support Group of 3

Distinct rate codes can be found in Appendix B.

## Supportive Employment

Supportive Employment services are individually designed to support children 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 to maintain competitive, customized or self-employment.

Supportive Employment is billed as one (1) service and can be delivered with or without the child/youth present.

Distinct rate code 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 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'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 must meet Level of Care (LOC) functional criteria and suffer from the symptoms and stress of chronic medical conditions **OR** illnesses that put individuals at risk for death before age 21.

Pain and Symptom Management is relief and/or control of the child's pain and suffering

related to their illness or condition.

Palliative Care benefits may not duplicate Hospice or other State Plan benefits accessible to participants.

## Palliative Care Bereavement

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 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'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 must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions **OR** illnesses that put individuals at risk for death before age 21.

Palliative Care Bereavement is help for participants and their families to cope with grief related to the participant's end-of-life experience. Bereavement counseling services are inclusive for those participants in receipt of Hospice care through a Hospice provider.

## 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 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'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 must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions **OR** illnesses that put individuals at risk for death before age 21. Palliative Care Massage Therapy works to improve muscle tone, circulation, range of motion and address physical symptoms related to a child's illness.

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

## 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 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'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 must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions **OR** illnesses that put individuals at risk for death before age 21.

Palliative Care Expressive Therapy (art, music, and play) helps children better understand and express their reactions to their illness or condition through creative and kinesthetic treatment.

Palliative Care Expressive Therapy benefits may not duplicate Hospice or other State Plan benefits accessible to participants

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

## Respite

HCBS Respite Services include two (2) distinct types: Planned Respite and Crisis Respite services.

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's functional, mental health/substance use disorder, developmental, and/or health care issues. The service is direct care for the child by staff trained to provide supervision and pro-social activities that match the child's developmental stage to maintain the child's health and safety. Planned Respite Services support the goals identified in the child's HCBS Plan of Care. Planned Respite also includes skill development activities.

Crisis Respite is a short-term intervention strategy for children and their families/caregivers which is necessary to address a child's behavioral health, developmental, or medical crisis or trauma, including acutely challenging emotional or medical crisis in which the child 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>7</sup>.

Planned Respite Services:

- Planned Respite Individual (up to 6 hours)

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<sup>7</sup> Subject to additions

- Planned Respite Individual per diem (over 6 hours)
- Planned Respite Group (up to 6 hours)

Crisis Respite Services:

- Crisis Respite (up to 6 hours)
- Crisis Respite (more than 6 hours, less than 12 hours)
- Crisis Respite (more than 12 hours, less than 24 hours)

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

## 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, individual-to-worker 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 participant's Plan of Care (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 participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational or speech therapies in the POC. In addition, Day Habilitation services may serve to reinforce skills, behaviors or lessons taught in other settings.

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

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

Children have a maximum daily amount of services that are available to individuals based upon their residence. Individuals 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 person'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 individual 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 individual 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 individual's skill level and to also prevent loss of skills necessary to accomplish the identified task.

*Enhancement* activities are provided to the individual through training and demonstration to promote growth and independence with an already acquired skill level and to support the participant'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 individual's plan of care (POC) 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 persons 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 person 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 individual and are only provided to the individual receiving HCBS services or to the family/caregiver in support of the child;
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the person has a progressive medical condition.
- The activities provided are consistent with the individual'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; and
- The provider is authorized to perform these services for HCBS recipients 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 and 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 person, 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 individual to perform simple measurements and tests; assisting with the preparation of complex modified diets; assisting with a prescribed exercise program; pouring, administering and 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 individual'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 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 and operated by a childcare 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 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, 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 is in an ineligible setting, such as in a hospital, ICF/IID or skilled nursing facility.

If a child needs assistance in the schools (educationally necessary) and a school employee will be providing the service, the service must be on the child's Individualized Education Plan (IEP) (504 plan services are not reimbursable by Medicaid) and reimbursed under the State Plan, not the HCBS waiver. If a child 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 home or other eligible residences of the enrolled child that are identified as necessary to support the health, welfare and safety of the child, or that enable the child to function with greater independence in the home and without which the child would require an institutional and/or more restrictive living setting. The need must be documented in the child's Plan of Care (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. 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 person moves to another home; if the current modifications are in need of repair, worn-out or unsafe; or if a participant 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's POC and this administrative directive for all children participating in the Children's Waiver.

The LDSS is responsible for authorization of these services for the individual until:

- The individual 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 individual is enrolled in a MMC plan; or
- The individual 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 individual is in enrolled in MMC.

For individuals newly enrolled in MMC, the LDSS will coordinate with the individual'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 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 NYSDOH 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/E-Mod and V-Mod Description and Cost Projection Form* with all supporting documents to the NYSDOH. 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/1115\\_waiver\\_amend.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm) and [https://www.health.ny.gov/health\\_care/medicaid/redesign/community\\_first\\_choice/](https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice/)

[e\\_option.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 MCO. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child’s needs or capabilities.

The LDSS must submit the *Description and Cost Projection Form* and the *Prior Approval Request* 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 NYSDOH will process the request and return a determination to the LDSS via the same method as the original submission.

Forms should be sent to DOH using one of the secure options below:

Mail	Fax	HCS
NYS DOH/OHIP Division of Long-Term Care Attn: CFCO-Children’s Prior Approval Unit OCP 16 <sup>th</sup> Floor 99 Washington Avenue Albany, NY 12210	1-518-408-6045	CFCO-ChildrenPriorApproval@Health.ny.gov

## Vehicle Modifications

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

The Care Manager (for FFS enrollees) or MCO (for managed care enrollees) secures a local contractor and/or evaluator qualified to complete the required work. In the case of vehicle modifications, the evaluators and modifiers are approved by the NYS Education Department’s Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR). 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, and the most cost- effective approach to fulfill the child’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 MCO is the provider of record for billing purposes. Services are only billed to Medicaid or the MCO once the contract work is verified as complete 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 the LDSS in conjunction with NYSDOH if exceeding established limits or MCO.

Vehicle Modifications are limited to the primary means of transportation for the child. The vehicle may be owned by the child or by a family member or non-relative who provides primary, consistent and ongoing transportation for the child. All equipment and technology used for entertainment is prohibited. Costs may not exceed current market value of vehicle. 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. 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 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 E-Mods, V-Mods, and AT in accordance with the child's POC and this administrative directive for all children participating in the Children's Waiver.

The LDSS is responsible for authorization of these services for the individual until:

- The individual 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 individual is enrolled in a MMC plan; or
- The individual 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 individual is in enrolled in MMC.

For individuals newly enrolled in MMC, the LDSS will coordinate with the individual'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 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 NYSDOH 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/E-Mod and V-Mod Description and Cost Projection Form* with all supporting documents to the NYSDOH. DOH's CFCO-Children's Prior Approval 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/1115\\_waiver\\_amend.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm) and [https://www.health.ny.gov/health\\_care/medicaid/redesign/community\\_first\\_choice\\_option.htm](https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm).

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

When a service is authorized the LDSS must submit the *Description and Cost Projection Form* and the *Prior Approval Request* 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 NYSDOH will process the request and return a determination to the LDSS via the same method as the original submission.

Forms should be sent to DOH using one of the secure options below:

Mail	Fax	HCS
NYS DOH/OHIP Division of Long-Term Care Attn: CFCO-Children’s Prior Approval Unit OCP 16 <sup>th</sup> Floor 99 Washington Avenue Albany, NY 12210	1-518-408-6045	CFCO- ChildrenPriorApproval@Health.ny.gov

## Adaptive and Assistive Equipment

Adaptive and Assistive Equipment includes technological aids and devices identified within the child’s Plan of Care (POC) that enable him/her to accomplish daily living tasks that are necessary to support the health, welfare, and safety of the child.

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

Adaptive and Assistive Equipment includes but 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 participant'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 participant 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 participant to interact with remote staff to ensure health and safety. Such devices cannot be used for the purpose of surveillance, but to support the person to live with greater independence, Devices to assist with medication administration, including tele-care devices that prompt, teach or otherwise assist the participant, Portable generators necessary to support equipment or devices needed for the health or safety of the person, and stretcher stations.

Adaptive and Assistive Equipment Services include: A. the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; B. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the

participants; C. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; D. training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates or authorized representatives of the participant; 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 participants.

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 MCO 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), CFCO or third-party resources.

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

The LDSS remains responsible for authorization of these services for the individual until:

- The individual 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 individual is enrolled in a MMC plan; or
- The individual 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 individual is in enrolled in MMC.

For individuals newly enrolled in MMC, the LDSS will coordinate with the individual'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 and/or equipment. In addition, the evaluator/assessor invoice may have to be paid. To address these potential barriers, the NYSDOH 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/E-Mod and V-Mod Description and Cost Projection Form* with all supporting documents to NYSDOH. The NYSDOH 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/1115\\_waiver\\_amend.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm) and [https://www.health.ny.gov/health\\_care/medicaid/redesign/community\\_first\\_choice\\_option.htm](https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm).

Cost Limits: AT costs cannot exceed \$15,000 per year without prior approval from the LDSS in conjunction with NYSDOH approval if exceeding established limits or the MCO. The State may consider exceptions when medically necessary, including but not limited to a significant change in the child's needs or capabilities.

For Adaptive and Assistive Equipment, the LDSS (for FFS enrollees) or MCO (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 is procured and the amount billed is equal to the purchased value.

LDSS or MCO 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, its expected benefit to the child, and the most cost-effective approach to fulfill the child'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 MCO once the equipment 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* and the *Prior Approval Request* 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 NYSDOH will process the request and return a determination to the LDSS via the same method as the original submission.

Forms should be sent to DOH using one of the secure options below:

Mail	Fax	HCS
NYS DOH/OHIP Division of Long-Term Care Attn: CFCO-Children’s Prior Approval Unit OCP 16 <sup>th</sup> Floor 99 Washington Avenue Albany, NY 12210	1-518-408-6045	CFCO- ChildrenPriorApproval@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 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 and family support, referral to community and social supports and service linkages using health information technology. Any child 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>8</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’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 client'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 client'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.

### Other Licensed Practitioner

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
OLP Licensed Evaluation	7900	90791	EP	15 Minutes	36/year
OLP Counseling - Individual	7901	H0004	EP	15 Minutes	4/day
OLP Counseling – Family (with or without the client present)	7901	H0004	HR – Family with client HS – Family without client	15 Minutes	4/day
OLP Crisis (Offsite, In-person only)	7902	H2011	EP, ET	15 Minutes	8/day

<sup>8</sup> Subject to additions

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
OLP Crisis Triage (By Phone)	7903	H2011	EP, GT	15 Minutes	2/day
OLP Crisis Complex Care (Follow up)	7904	90882	EP, TS	5 Minutes	4/day
OLP Counseling - Group	7905	H0004	HQ, EP	15 Minutes	4/day
Offsite – OLP Evaluation Individual 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	36/year for Evaluation  4/day for Individual  4/day Family
Offsite – OLP Counseling Group	7927	H0004	EP, HQ, SC	15 Minutes	4/day

**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 - OLP Counseling – Two Services – Family AND Individual provided on same day – combine both services on one claim line</b>	7901	15 Minutes	8/day

## 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 client)	7911	H0036	EP	15 Minutes	6/day
CPST Service Professional - Group	7912	H0036	EP, HQ	15 Minutes	4/day
Offsite- CPST Individual and/or Family (with or without the client)	7921	H0036	EP, SC	15 Minutes	6/day
Offsite – CPST Group	7928	H0036	EP, HQ, SC	15 Minutes	4/day

## Psychosocial Rehabilitation

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
PSR Service Professional	7913	H2017	EP	15 Minutes	8/day
PSR Service Professional - Group	7914	H2017	EP, HQ	15 Minutes	4/day
Offsite- PSR Individual	7922	H2017	EP, SC	15 Minutes	8/day
Offsite – PSR Group	7929	H2017	EP, HQ, SC	15 Minutes	4/day

## Family Peer Support Services

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
FPS Service Professional	7915	H0038	EP, UK	15 Minutes	8/day

<b>Service</b>	<b>Rate Code</b>	<b>Procedure Code</b>	<b>Modifier</b>	<b>Unit Measure</b>	<b>Unit Limit</b>
FPS Service Professional - Group	7916	H0038	EP, UK, HQ	15 Minutes	6/day
Offsite- FPSS Individual	7923	H0038	EP, UK, SC	15 Minutes	8/day
Offsite – FPSS Group	7930	H0038	EP, HQ, SC, UK	15 Minutes	6/day

## Youth Peer Supports

<b>Service</b>	<b>Rate Code</b>	<b>Procedure Code</b>	<b>Modifier</b>	<b>Unit Measure</b>	<b>Unit Limit</b>
YPS Service Professional	7917	H0038	EP	15 Minutes	8/day
YPS Service Professional - Group	7918	H0038	EP, HQ	15 Minutes	6/day
Offsite- YPS Individual	7923	H0038	EP, SC	15 Minutes	8/day
Offsite –YPS Group	7930	H0038	EP, HQ, SC	15 Minutes	6/day

## Crisis Intervention

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
<b>Mobile Crisis</b>					
One-person response: Licensed	7906	H2011	EP, HO	15 Minutes	6/day
Two-person Response: Licensed and Unlicensed/Certified Peer	7907	H2011	EP, HT	15 Minutes	6/day
Two-person Response: Both Licensed	7908	H2011	EP	15 Minutes	6/day
Two-person Response: Licensed and Unlicensed/Certified Peer	7909	S9484	EP	Per Diem	1/day
Two-person Response: Licensed and Unlicensed/Certified Peer	7910	S9485	EP	Per Diem	1/day
Two Person Response: Both Licensed (90-180 minutes)	7936	S9484	EP, HO	Per diem (90- 180 minutes)	1/day
Two Person Response: Both Licensed (over 3 hours)	7937	S9485	EP, HO	Per diem greater than 180 minutes	1/day
<b>Mobile Follow up Services</b>					
One Person Face-to- Face Follow-Up: Licensed	7938	H2011	TS, HO	15 minutes	6/day
One Person Face-to- Face Follow-Up: Unlicensed/Certified Peer	7939	H2011	TS, HM, HA	15 minutes	6/day
Two-person Face-to- Face Follow-Up: Licensed and Unlicensed	7940	H2011	TS, HT	15 minutes	6/day
<b>Telephonic Follow up Services</b>					

Telephonic Follow-Up: Licensed	7941	H2011	TS, HO, GT	15 minutes	4/day
CI Telephonic follow up Unlicensed/Certified Peer	7942	H2011	TS, HM, GT	15 minutes	4/day
<b>Crisis Residential Services</b>					
Residential Crisis Support	7943	H2013	HA, TF	per diem	1/day
Intensive Crisis Residence (ICR) 18-20 years	7944	H2013	HA, HK	per diem	1/day
Children's Crisis Residence	7945	H2013	HA	per diem	1/day

## Appendix B – Aligned HCBS Rate Code Descriptions<sup>9</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’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 client'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 client'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.

### Caregiver Family Supports and Services

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Caregiver Family Supports and Services - Individual	8003	H2014	UK, HA	15 minutes	12/day
Caregiver Family Supports and Services - Group of 2	8004	H2014	HA, UK, UN	15 minutes	12/day
Caregiver Family Supports and Services - Group of 3	8005	H2014	HA, UK, UP	15 minutes	12/day

<sup>9</sup> Subject to additions



## 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

## Community Advocacy Training and Support

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Community Advocacy and Support - Individual	8009	H2015	HA	15 minutes	12/day
Community Advocacy and Support – Group of 2	8010	H2015	HA, UN	15 minutes	12/day
Community Advocacy and Support – Group of 3	8011	H2015	HA, UP	15 minutes	12/day

## 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

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 participant’s physician order

## Palliative Care Bereavement

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

## 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

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

## 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 hours)	8024	S5151	HA	Per Diem	1/day
Planned Respite - Group (up to 6 hours)	8027	S5150	HA, HQ	15 minutes	24/day

## 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–more than 6 hours, less than 12 hours	8029	S5151	HA, ET	Per Diem	1/day
Crisis Respite - Individual (12+ hours, less than 24 hours)	8030	S5151	HA, ET, HK	Per Diem	1/day

## 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

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 more	8014	H2014	HA, UP	15 minutes	24/day

## FFS Billing for Environmental Modifications (EMOD), Vehicle Modifications (VMOD) and Adaptive and Assistive Technology (AT)

The Care Manager or C-YES Coordinator will coordinate requests for EMODS, VMODS and AT directly with the Local Department of Social Service in conjunction with New York State Department of Health (NYSDOH) for children not enrolled in a Managed Care Plan. Requests for these services will be managed directly with the Managed Care Plan for those children 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 individual'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 NYSDOH along with the request for service packet in order to obtain approval of the request.

## MMC Billing for Environmental Modifications (EMOD), Vehicle Modifications (VMOD) 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 NYSDOH.

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

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’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 client'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 client's record. In addition to requiring concurrent utilization review and authorization as per the *Children’s Home and Community Based Services Provider Manual* and any subsequent edits, the MMCP may conduct post-payment administrative reviews to ensure services were provided appropriately.

### 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	\$1000.00	\$15,000 per year calendar

## 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	\$1000.00	\$15,000 per calendar year

## Adaptive and Assistive Equipment

Service	Rate Code	Procedure Code	Modifier	Unit Measure	Unit Limit
Adaptive and Assistive Equipment	8037	T2028	HA	\$1.00	\$15,000 per calendar year
Adaptive and Assistive Equipment	8038	T2028	HA, V1	\$10.00	\$15,000 per calendar year
Adaptive and Assistive Equipment	8039	T2028	HA, V2	\$100.00	\$15,000 per calendar year
Adaptive and Assistive Equipment	8040	T2028	HA, V3	\$1000.00	\$15,000 per calendar year