NEW YORK STATE CHILDREN’S HEALTH AND BEHAVIORAL HEALTH (BH) SERVICES – CHILDREN’S MEDICAID SYSTEM TRANSFORMATION BILLING AND CODING MANUAL

Table of Contents

General ... 5

Purpose of this Manual ... 5

New Children and Family Treatment and Support Services ... 6

Children's Aligned HCBS ... 6

Health Home Care Management ... 7

Additional State Plan BH Services ... 7

Services Included in or Excluded from Capitation Payments to Medicaid Managed Care Plans ... 8

Fundamental Requirements ... 8

Provider Designation to Deliver Services ... 8

Medicaid-Enrolled Provider ... 9

Medicaid Managed Care Plan Contracting ... 9

Rates ... 10

Government Rates ... 10

Claims ... 11

General Claim Requirements ... 11

Enrollment Status ... 11

Medicaid Fee-For-Service Claiming (eMedNY) ... 11

Medicaid Managed Care Plan Claiming ... 12

Multiple services provided on the same date to the same individual ... 13

Submitting Claims for Daily Billed Services ... 13

Claims Coding Table ... 13

Claims Testing ... 13

Claiming Information for Medicaid New EPSDT Children and Family Treatment and Support Services ... 14

Service Combinations ... 14

Provider Assistance ... 17

Where to Submit Questions and Complaints ... 17

New Medicaid Children and Family Treatment and Support Services ... 18

1. Other Licensed Practitioner (OLP) ... 18

OLP – Licensed Evaluation ... 18

OLP – Counseling ... 19

OLP - Individual and Family Counseling ... 19

OLP – Group Counseling ... 19

OLP - Crisis Off-site 20
OLP - Crisis Triage (by telephone) 20
OLP - Crisis Complex Care (follow-up to Crisis) 20
2. Community Psychiatric Support and Treatment (CPST) 21
CPST - Service Professional – Individual/Family 21
CPST - Service Professional - Group 21
3. Psychosocial Rehabilitation (PSR) 22
PSR - Service Professional - Individual 22
PSR - Service Professional – Group 22
4. Family Peer Support Services (FPS) 22
FPS Service Professional - Individual 23
FPS Service Professional - Group 23
5. Youth Peer Support and Training (YPS) 23
YPS Service Professional - Individual 24
YPS Service Professional - Group 24
6. Crisis Intervention 24
Crisis Intervention – One Licensed Practitioner 25
Crisis Intervention – One Licensed Professional and One Peer Support 25
Aligned Home and Community Based (HCBS) Services 27
1. Caregiver Family Support and Services 27
2. Prevocational Services 27
3. Community Self-Advocacy Training and Support 27
4. Supportive Employment 28
5. Palliative Care Pain and Symptom Management 28
6. Palliative Care Bereavement 28
7. Palliative Care Massage Therapy 29
8. Palliative Care Expressive Therapy 29
9. Respite 29
10. Day Habilitation 30
11. Community Habilitation 31
12. Accessibility Modifications 34
13. Adaptive and Assistive Equipment 35
14. Non-Medical Transportation 35

Health Home Care Management 36
BH State Plan Services..... 36
Appendix A – New Children and Family Treatment and Support Services Rate Code Descriptions 37
Other Licensed Practitioner 37
Psychosocial Rehabilitation 39
Family Peer Support Services..... 39
Youth Peer Support Services..... 40
Appendix B – Aligned HCBS Rate Code Descriptions 42
Caregiver Family Supports and Services 42
Pre-Vocational Services..... 43
Community Advocacy Training and Support 43
Palliative Care Pain & Symptom Management..... 45
Palliative Care Bereavement..... 45
Palliative Care Massage Therapy 45
Palliative Care Expressive Therapy..... 46
Respite - Planned 46
Respite - Crisis..... 47
Day Habilitation 48
Community Habilitation..... 48
Accessibility Modifications..... 49
Adaptive and Assistive Equipment..... 50

General

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 Alcohol and Substance Abuse Services (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.

The implementation of the new services and the transition to benefits and populations to Managed Care included in the Children's Transformation will be phased in throughout NYS beginning on January 1, 2019, and will include the transition of selected children's benefits to Medicaid Managed Care. *The Children's Transformation, is subject to Centers for Medicare and Medicaid (CMS) approvals and State approvals, and the timing of those approvals. Thus, the effective dates referred to in this manual may be updated accordingly.*

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

This system transformation is for services available to children, defined as an individual under the age of 21.

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. 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.

[1] Additional guidance related to Community First Choice Option (CFCO) will be incorporated into this manual at a future date

Appendices to this manual include listing of rate code and Current Procedural Terminology (CPT) code/modifier code. The CPT code to be used is listed for each service.

New Children and Family Treatment and Support Services

The following services have been created and will be phased in and available as part of the Medicaid State Plan. This phase in will begin January 1, 2019. Please see dates next to each service.

Six newly established Early Periodic Screening, Diagnostic and Treatment (EPSDT)[2] Medicaid State Plan behavioral health services:

- 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 and Training (YPST) - 1/1/2020
- Crisis Intervention – 1/1/2020

For children enrolled in a Medicaid Managed Care Plan these services will be billed directly to the Plan.

Children's Aligned HCBS

Most services previously delivered under agency-specific 1915(c) waivers will now be delivered under concurrent waiver authorities that allow children, and new and aligned services, to be enrolled in Managed Care (unless otherwise exempt or excluded for another reason), and the services to be 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. The MMCP capitation payment will not include these services.

The following services will be 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.

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

Information on eligibility for these services can be found in the Transition Plan for the Children's System Transformation.

New Aligned Children's Home and Community Based Services (HCBS)

- Caregiver Family Supports and Services
- Pre-Vocational Services
- Community Advocacy Training and Support
- Supported Employment
- Palliative Care-Pain & Symptom Management
- Palliative Care- Bereavement Service
- Palliative Care Massage Therapy
- Palliative Care- Expressive Therapy
- Respite- Planned
- Respite- Crisis
- Day Habilitation
- Community Habilitation
- Accessibility Modifications
- Adaptive and Assistive Equipment
- Non-Medical Transportation[3]

Health Home Care Management

Concurrent with the managed care carve-in on April 1, 2019, children eligible for HCBS will receive care management through Health Homes. The care coordination service now provided under each of the six children's 1915(c) waivers will transition to Health Home beginning January 1, 2019.

Health Home is an optional benefit; therefore, children may opt out of Health Home care management. The State-designated Independent Entity 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. The Independent Entity 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 BH Services

The following State Plan BH services available to children under age 21 will be transitioned into Medicaid Managed Care on July 1, 2019, and will follow billing

[3] 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.

procedures defined in New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual Billing and Coding Manual:

- Assertive Community Treatment (ACT) (minimum age is 18 for medical necessity for this adult oriented service)
- 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 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 therefore 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. MMCPs will be reimbursed on a FFS basis outside the capitation rate by submitting claims for Aligned 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 Aligned HCBS Coding Table.

Fundamental Requirements

Provider Designation to Deliver Services

Providers of the following services are required to receive a designation from NYS to provide and be reimbursed for new Children and Family Treatment and Support Services and Aligned Children's HCBS

- Community Psychiatric Support and Treatment (CPST)
- Other Licensed Practitioners (OLP)
- Psychosocial Rehabilitation (PSR)
- Family Peer Support Services (FPSS)
- Youth Peer Support and Training (YPST)
- Crisis Intervention (CI)
- Caregiver Family Supports and Services
- Community Advocacy Training and Support
- Day Habilitation
- Community Habilitation
- Respite (Planned & Crisis)
- Palliative Care Bereavement
- Palliative Care Massage Therapy
- Palliative Care Pain & Symptom Management
- Palliative Care Expressive Therapy
- Pre-Vocational Services
- Supported Employment

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

Medicaid Managed Care Plan Contracting

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

A 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

Government Rates

NYS law requires that Medicaid Managed Care Plans pay Ambulatory Patient Group (APG) rates or Government rates (otherwise known as Medicaid fee-for-service rates) for services administered by a MMCP.

Upon the transition date of the respective services, MMCPs will be required to pay APG or government rates for at least 24 months. This applies to the following services:

- Current BH services being carved into Managed Care,
- Six new Children and Family Treatment and Support Services, and
- Aligned Children's HCBS

Productivity Adjustment

Beginning on the State Plan effective date of each respective service and ongoing for one year from that date, providers will be paid higher 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 receive a 25 percent bump to the rates for the first 6 months and an 11 percent bump for the second 6 months.

Claims

General Claim Requirements[4]

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.

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, 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 (before delivering HCBS), and
- Plan enrollment status

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.

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[4] 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.

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 MMCP 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[5].

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); and
- Units of service

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.

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.

[5] Attention MMCPs- This field serves a dual purpose and is already used by MMCPs to report the weight of a low birth weight baby.

Multiple Services Provided on the Same Date to the Same 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.[6]

Submitting Claims for Daily Billed Services

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

Claims Coding Table

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 annual claim limits and "soft" unit limits will be based on medical necessity and subject to post-payment review. Documentation of the medical necessity for extended durations must be kept on file in the client's record.

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.

[6] The service combination grid is being finalized and is subject to additions

Providers are expected to claims test 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 New EPSDT Children and Family Treatment and Support Services

Service Combinations[7]

Only certain combinations of aligned HCBS and State Plan services are allowed by Medicaid within an individual's current treatment plan. The grid below shows the allowable service combinations.

[7] The service combination grid is being finalized and is subject to additions

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
Day Habilitation	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Community Habilitation	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Caregiver & Family Support and Services	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Respite	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Prevocational Services	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Supported Employment	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Community Self-Advocacy Training and Supports	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Other Licensed Practitioner (OLP)	No	No	No	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes
Community Psychiatric Supports and Treatment (CPST)	Yes	Yes	Yes	No	No	No	Yes	Yes	-	Yes	Yes	Yes
Psychosocial Rehabilitation (PSR)	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	-	Yes	Yes
Supported Employment	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Community Self-Advocacy Training and Supports	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

*These services available to youth age 18 and older

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
Other Licensed Practitioner (OLP)	No	No	No	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes
Community Psychiatric Supports and Treatment (CPST)	Yes	Yes	Yes	No	No	No	Yes	Yes	-	Yes	Yes	Yes
Psychosocial Rehabilitation (PSR)	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	-	Yes	Yes
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

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

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

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

Specific to a mental health provider/service: OMH-Managed-Care@omh.ny.gov

Specific to a substance use disorder provider/service: PICM@oasas.ny.gov

Specific to an OPWDD provider/service: Central.Operations@opwdd.ny.gov

New Medicaid Children and Family Treatment and Support Services[8]

Additional information on the New 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*.

1. Other Licensed Practitioner (OLP)

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

- Evaluation
- Counseling
- Crisis

An OLP is an individual who is licensed in NYS to diagnose, and/or treat individuals with a physical illness, mental illness, substance use disorder, or functional limitations at issue, operating within the scope of practice defined in NYS law and in any setting permissible under State Practice Law.

The following practitioners may provide and be reimbursed for OLP services:

- Licensed Psychoanalyst
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Mental Health Counselor
- Licensed Master Social Worker under the supervision or direction of a Licensed Clinical Social Worker, Licensed Psychologist or a Psychiatrist.

OLP can be provided to individuals, families and groups, and can be provided on-site or off-site. When submitting claims for any of the OLP services the following rules apply:

OLP – Licensed Evaluation

Licensed Evaluation (Assessment) is the process of identifying a child/youth individual's behavioral strengths and weaknesses, problems and service needs, through the observation and a comprehensive evaluation of the child/youth current mental, physical and behavioral condition and history. The assessment is the basis for establishing a

[8] Subject to additions

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.
- Claims are billed daily, in 15-minute units, with a limit of 10 units per day.
- 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 CPT code as noted in the rate table
- Off-site is billed daily with a limit of 1 unit per client, per day.

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 diagnosed behavioral health disorder, 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 Family Counseling

- Claims for OLP individual counseling services are defined using distinct rate codes based on whether the service was provided to an individual or the family (with or without the individual present or attending) and whether the service was provided on-site or off-site. 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).
- Each counseling claim must include the CPT code.
- Family counseling claims must also include the appropriate modifier in addition to CPT code
- A separate claim is submitted for off-site
- Off-site is billed daily with a limit of 1 unit per client, per day.

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.
- Group size may not exceed more than eight members.

- Group sessions may be provided on-site or off-site.
- When group sessions are provided offsite, 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.
- When submitting claims for on-site services, the provider will submit all claims using the appropriate rate code.
- Off-site is billed daily with a limit of 1 unit per client, 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 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
- 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

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.
- Crisis Complex Care is provided by telephone.

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

2. 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.

Claims for CPST services are defined based individual/family 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/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).
- Each CPST claim must include the CPT code.
- 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. These would both have the same procedure code
- Off-site is billed daily with a limit of 1 unit per client, per day.

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.
- 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 offsite, 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 with a limit of 1 unit per client, per day.

3. Psychosocial Rehabilitation (PSR)

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.
- PSR may be provided on-site or off-site.
- Off-site PSR 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.
- Off-site is billed daily with a limit of 1 unit, per client, 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
- 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 offsite, 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, with a limit of 1 unit, per client, per day

4. Family Peer Support Services (FPS)

FPS 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. FPS 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.

FPS 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:

FPS Service Professional - Individual

- Requires the use of the appropriate rate code (see Appendix A).
- FPS services are billed daily, in 15-minute units, with a limit of eight units per day (2-hour daily maximum).
- Each FPS claim must include the CPT code.
- FPS may be provided on-site or off-site
- Off-site FPS 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.
- Off-site is billed daily with a limit of 1 unit per client, per day.

FPS Service Professional - Group

- Requires the use of the appropriate rate code (see Appendix A).
- FPS group services are billed daily, in 15-minute units, with a limit of six units per day (1.5 hours).
- Each FPS group claim must include the CPT code.
- Group size may not exceed more than 12 members.
- FPS group sessions may be provided on-site or off-site
- When group sessions are provided offsite, 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 FPS is billed daily, with a limit of 1 unit per client, per day

5. Youth Peer Support and Training (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.
- 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. Both will include the same procedure code.
- Off-site is billed daily with a limit of 1 unit per client, 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.
- 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 offsite, 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 YPS is billed daily, with a limit of 1 unit per client, per day

6. 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 is separated into five different types of sessions:

- Crisis Intervention Off-site/Follow-up (one licensed practitioner),
- Crisis Intervention Off-site/Follow-up (one licensed practitioner and one peer support),
- Crisis Intervention Off-site/Follow-up (two licensed practitioners),

- Crisis Intervention Off-site, 90-180 minutes (two practitioners, one must be licensed) and;
- Crisis Intervention Off-site, per diem, Minimum of three hours (two practitioners, one must be licensed).

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 Practitioner

- Crisis Intervention –One Licensed Practitioner claims require 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.
- This service is provided off-site, a separate off-site claim is not permissible.

Crisis Intervention – One Licensed Professional and One Peer Support

- Crisis Intervention One Licensed Professional and One Peer Support claims require 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 and require a minimum of three hours of face to face contact with two practitioners.
- Each service must include the CPT code.
- This service is provided off-site, a separate off-site claim is not permissible.

Crisis Intervention – Two Licensed Practitioners

- Crisis Intervention Two Licensed Practitioners require 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 and require a minimum of three hours of face to face contact with two practitioners.
- Each service must include the CPT code.
- This service is provided off-site, a separate off-site claim is not permissible.

Crisis Intervention – 90-180 minutes and two clinicians, including one licensed

- Crisis Intervention 90-180 minutes and two clinicians, including one licensed require the use of the appropriate rate code (see Appendix A).
- Services are billed per diem
- Each service must include the CPT code.

- Services are billed daily
- This service is provided off-site, a separate off-site claim is not permissible.

Crisis Intervention – Per Diem Three Hours, Two Clinicians, including one licensed

- Crisis Intervention Per Diem Three Hours, Two Clinicians, including one licensed, including one licensed require the use of the appropriate rate code (see Appendix C).
- Services are billed per diem
- Each service must include the CPT code.
- Services are billed daily
- This service is provided off-site, a separate off-site claim is not permissible.

Aligned Home and Community Based (HCBS) Services

1. 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.

- 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.

2. Prevocational Services

Prevocational services are individually designed to prepare a child age 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.

3. 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 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

HCBS Community Self-Advocacy Training and Support is divided into individual and group services. 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.

4. Supportive Employment

Supported employment services are individually designed to support children age 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.

Distinct rate code can be found in Appendix B.

5. Palliative Care Pain and Symptom Management

Pain and Symptom Management – Relief and/or control of the child's pain and suffering related to their illness or condition.

6. Palliative Care Bereavement

Bereavement Service – Counseling for the child and family to cope with grief related to the child's end-of-life experience. Bereavement counseling services are available to children receiving hospice care.

7. Palliative Care Massage Therapy

Massage Therapy – To improve muscle tone, circulation, range of motion and address physical symptoms related to a child's illness

8. Palliative Care Expressive Therapy

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

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. Palliative care includes the following services:

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

9. 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 enrollee's health and safety. Planned Respite Services support the goals identified in the child's HCBS for Children 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[9].

Planned Respite Services:

- Planned Respite - Individual (under 4 hours)
- Planned Respite – Individual per diem
- Planned Respite - Group (under 4 hours) Planned Respite - Individual per diem

Crisis Respite Services:

- Crisis Respite (under 4 hours)
- Crisis Respite (more than 4 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.

10. 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 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 DH cannot be billed as overlapping services. Supplemental Day Habilitation services, are those services provided on weekends and/or on weekdays with a service start time after 3:00pm Supplemental Day Habilitation services are not

[9] Subject to additions

available to individuals residing in certified residential settings, because the residence is paid for staffing on weekday evenings and anytime on weekends.

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.

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

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.

11. Community Habilitation

Community Habilitation covers services and supports related to the person's acquisition, maintenance and enhancement of skills necessary to independently perform ADLs, 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 includes, but is not limited to:

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

Some specific IADL services available for skills training includes, but is 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 are 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 a direct service professional can perform under applicable exemptions from the Nurse Practice Act.

Some specific health-related tasks available for assistance includes, but is not limited to:

Teaching the individual in performing 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 child care 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 week-days 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 this 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

12. Accessibility Modifications

Accessibility Modifications provide internal and external physical adaptations to the home or other eligible residences of the enrolled child that are necessary to support the health, welfare and safety of the child and enable the child to function with greater independence. Under this benefit there are two types of allowable Accessibility Modifications: Environmental & Vehicle.

<u>Environmental Modifications</u>
This service provides internal and external physical adaptations to the home or other eligible residences 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 in the home and without which the child would require institutional and/or more restrictive living setting.

<u>Vehicle Modifications</u>
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.

HCBS Accessibility Modifications is billed with distinct rate codes for

- Accessibility Modifications - $1.00 Unit

- Accessibility Modifications - $10.00 Unit
- Accessibility Modifications - $100.00 Unit
- Accessibility Modifications - $1000.00 Unit

- Vehicle Modifications -$1.00 Unit
- Vehicle Modifications- $10.00 Unit
- Vehicle Modifications- $100.00 Unit
- Vehicle Modifications- $1000.00 Unit

Distinct rate codes can be found in Appendix B.

13. Adaptive and Assistive Equipment

Adaptive and Assistive Equipment provides technological aids and devices identified within the child's Plan of Care (POC) which 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.

HCBS Adaptive and Assistive Equipment is billed with distinct rate codes for:

- Adaptive and Assistive Equipment - $1.00 Unit
- Adaptive and Assistive Equipment - $10.00 Unit
- Adaptive and Assistive Equipment - $100.00 Unit
- Adaptive and Assistive Equipment - $1000.00 Unit

Distinct rate codes can be found in Appendix B.

14. Non-Medical Transportation

Non-Medical Transportation will be billed to Medicaid FFS. Please refer to the Medicaid Transportation Guidelines for more details.

Health Home Care Management

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.

BH State Plan Services

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 – New Children and Family Treatment and Support Services Rate Code Descriptions[10]

Other Licensed Practitioner

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
OLP Licensed Evaluation	7900	90791	N/A	15 Minutes	10
OLP Counseling - Individual	7901	H0004	N/A	15 Minutes	4
OLP Crisis (Offsite, In-person only)	7902	H2011	N/A	15 Minutes	8
OLP Crisis Triage (By Phone)	7903	H2011	N/A	15 Minutes	2
OLP Crisis Complex Care (Follow up)	7904	90882	N/A	5 Minutes	4
OLP Counseling - Group	7905	H0004	HQ	15 Minutes	4

[10] Subject to additions

Offsite – OLP Individual	7920	90791 or H0004 depending on service provided	N/A	15 Minutes	1
Offsite – OLP Counseling Group	7927	H0004	HQ	15 Minutes	1

Community Psychiatric Support and Treatment

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
CPST Service Professional	7911	H0036	N/A	15 Minutes	6
CPST Service Professional - Group	7912	H0036	HQ	15 Minutes	4
Offsite- CPST Individual	7921	H0036	N/A	15 Minutes	1
Offsite – CPST Group	7928	H0036	HQ	15 Minutes	1

Psychosocial Rehabilitation

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
PSR Service Professional	7913	H2017	N/A	15 Minutes	8
PSR Service Professional - Group	7914	H2017	HQ	15 Minutes	4
Offsite- PSR Individual	7922	H2017	N/A	15 Minutes	1
Offsite – PSR Group	7929	H2017	HQ	15 Minutes	1

Family Peer Support Services

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
FPS Service Professional	7915	H0038	N/A	15 Minutes	8
FPS Service Professional - Group	7916	H0038	HQ	15 Minutes	6
Offsite FPS/YPS - Individual	7923	H0038	N/A	15 Minutes	1

Offsite – FPS/YPST - Group	7930	H0038	HQ	15 Minutes	1

Youth Peer Support Services

Service	**Rate Code**	**CPT Code**	**Modifier**	**Unit Measure**	**Unit Limit/day**
YPS Service Professional	7917	H0038	N/A	15 Minutes	8
YPS Service Professional - Group	7918	H0038	HQ	15 Minutes	6
Offsite FPS/YPS - Individual	7923	H0038	N/A	15 Minutes	1
Offsite – FPS/YPST Group	7930	H0038	HQ	15 Minutes	1

Crisis Intervention

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
CI 1 Licensed Practitioner	7906	H2011	N/A	15 Minutes	6
CI 1 Licensed Practitioner & 1 Peer Support	7907	H2011	N/A	15 Minutes	6
CI 2 Licensed Practitioners	7908	H2011	N/A	15 Minutes	6
CI 90-180 min & 2 clinicians, 1 licensed	7909	S9484	N/A	Per Diem	1
CI Per diem 3 hrs., 2 clinicians, 1 licensed	7910	S9485	N/A	Per Diem	1

Appendix B – Aligned HCBS Rate Code Descriptions[11]

Caregiver Family Supports and Services

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Caregiver Family Supports and Services - Individual	8003	H2014	HR or HS	15 minutes	12
Caregiver Family Supports and Services - Group of 2	8004	H2014	HQ and HR or HS	15 minutes	12
Caregiver Family Supports and Services - Group of 3	8005	H2014	HQ and HR or HS	15 minutes	12

[11] Subject to additions

Pre-Vocational Services

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Prevocational Services - Individual	8006	T2015	N/A	Per hour	2
Prevocational Services - Group of 2	8007	T2015	HQ	Per hour	2
Prevocational Services - Group of 3	8008	T2015	HQ	Per hour	2

Community Advocacy Training and Support

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Community Advocacy and Support - Individual	8009	H2015	N/A	15 minutes	12
Community Advocacy and Support - Group of 2	8010	H2015	HQ	15 minutes	12
Community Advocacy and Support - Group of 3	8011	H2015	HQ	15 minutes	12

Supported Employment

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Supported Employment	8015	H2023	N/A	15 minutes	12

Palliative Care Pain & Symptom Management

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Palliative Care Pain and Symptom Management	8016	G8512	N/A	per visit	No limit, as required by participant's physician

Palliative Care Bereavement

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/month
Palliative Care Bereavement Services	8017	90832	N/A	Per 12 minutes	5 not to exceed 60 minutes per calendar year

Palliative Care Massage Therapy

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/year
Palliative Care Massage Therapy	8018	97124	N/A	Per appointment	12 appointment limit can be exceeded when medically necessary

Palliative Care Expressive Therapy

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/year
Palliative Care Expressive Therapy	8019	90832	N/A	hour	48 limit can be exceeded when medically necessary

Respite - Planned

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Planned Respite - Individual (under 4 hours)	8023	S5150	N/A	Per 15 minutes	16
Planned Respite - Individual per diem (4+ hours)	8024	S5151	N/A	Per Diem	1
Planned Respite - Group (under 4 hours)	8027	S5150	HQ	Per 15 minutes	16

Respite - Crisis

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Crisis Respite - under 4 hours	8028	S5150	N/A	Per 15 minutes	16
Crisis Respite - more than 4 hours, less than 12 hours	8029	S5151	N/A	Per Diem	1
Crisis Respite - (12+ hours, less than 24 hours)	8030	S5151	N/A	Per Diem	1

Day Habilitation

Service	**Rate Code**	**CPT Code**	**Modifier**	**Unit Measure**	**Unit Limit/day**
Day HCBS Habilitation	7933	H2014	N/A	15 minutes	24
Day HCBS Habilitation - Group of 2	7934	H2014	HQ	15 minutes	24
Day HCBS Habilitation - Group of 3 or more	7935	H2014	HQ	15 minutes	24

Community Habilitation

Service	**Rate Code**	**CPT Code**	**Modifier**	**Unit Measure**	**Unit Limit/day**
Community HCBS Habilitation	8012	H2014	N/A	15 minutes	24
Community HCBS Habilitation - Group of 2	8013	H2014	HQ	15 minutes	24
Community HCBS Habilitation - Group of 3 or more	8014	H2014	HQ	15 minutes	24

Accessibility Modifications

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit
Accessibility Modifications	8032	S5165	N/A	$1.00	N/A
Accessibility Modifications	8034	S5165	N/A	$10.00	N/A
Accessibility Modifications	8035	S5165	N/A	$100.00	N/A
Accessibility Modifications	8036	S5165	N/A	$1000.00	N/A
Vehicle Modifications	8041	T2039	N/A	$1.00	N/A
Vehicle Modifications	8042	T2039	N/A	$10.00	N/A
Vehicle Modifications	8043	T2039	N/A	$100.00	N/A
Vehicle Modifications	8044	T2039	N/A	$1000.00	N/A

Adaptive and Assistive Equipment

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit
Adaptive and Assistive Equipment	8037	T2028	N/A	$1.00	N/A
Adaptive and Assistive Equipment	8038	T2028	N/A	$10.00	N/A
Adaptive and Assistive Equipment	8039	T2028	N/A	$100.00	N/A
Adaptive and Assistive Equipment	8040	T2028	N/A	$1000.00	N/A