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

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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 system¹.

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.

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.

¹ Additional guidance related to CFCO will be incorporated into this manual at a future date

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

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.

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
- Respite- Planned
- Respite- Crisis
- Habilitation
- Accessibility Modifications
- Adaptive and Assistive Equipment
- Non-Medical Transportation³

Health Home Care Management

Concurrent with the managed care carve-in on 4/1/2019, 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 procedures defined in [New York State Health and Recovery Plan \(HARP\) / Mainstream Behavioral Health Billing and Coding Manual Billing and Coding Manual](#):

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](#).

- 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
- Habilitation
- Respite (Planned & Crisis)
- Palliative Care
- 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.

Claims

General Claim Requirements⁴

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.

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.

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](#).

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 and 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 billing⁵.

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

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.

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.

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.

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

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.

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

Claiming for Staff Transportation

In addition to the claim submitted for services provided, an additional claim may be submitted for staff transportation. The staff transportation rate will cover the cost of provider staff travel (mileage or public transportation fares) to off-site service locations. There is no separate reimbursement for "staff time" while in travel status. Staff transportation is claimed under the recipient's Medicaid ID (CIN) and is only allowable for a single staff person for a single service.

A separate claim must be submitted when claiming mileage or transportation. There are two types of travel rate codes: Transportation and Mileage. The fee schedule defines the rate codes. All claims must be submitted with the appropriate rate, CPT codes and modifiers (if applicable).

Transportation Claims

- Pays a flat fee and is used for any mode of public transit (e.g., taxi, subway, bus)
- Billed monthly using the first day of the month as the date of service
- A round-trip would count as one unit, with a limit of 31 units per calendar month per individual
- One transportation claim per individual, per day
- Separate days will be billed on separate claim lines, one unit per day

Mileage Claims

- Billed daily in per mile units
- Pays per mile with a limit of 60 miles per round trip
- The number of miles traveled is indicated in the unit field of the claim line

Service Combinations⁷

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
Habilitation	Yes	Yes	Yes	No	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

*These services available to youth age 18 and older

NYS Allowable Billing Combinations 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
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

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	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 Services⁸

Additional information on the New Medicaid State Plan Services can be found in the *Medicaid State Plan 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 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.

⁸ Subject to additions

- Claims for OLP initial evaluation are defined using distinct rate codes. Off-site services would 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.
- 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:
- A separate claim should be submitted for staff transportation.

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
- A separate claim is submitted for staff transportation.

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 submitting claims for on-site services, the provider will submit all claims using the appropriate on-site/non-travel off-site rate code.
- Claims for OLP initial evaluation are defined using distinct rate codes. Off-site services would 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.
- A separate claim is submitted for staff transportation.

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

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/non-travel off-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 would 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.
- billed with the service rate code, and an additional line with the off-site add-on rate code.
- Off-site daily with a limit of 1 unit 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.

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 billed daily with a limit of 1 unit, per client, per day.

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
- Off-site PSR 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 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
- Off-site FPS 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 billed daily with a limit of 1 unit 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
- Off-site YPS billed daily, with a limit of 1 unit 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.

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.

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.
- Services are billed daily

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

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

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

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 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:

- Pain and Symptom Management – Relief and/or control of the child’s pain and suffering related to their illness or condition.
- 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.
- Massage Therapy – To improve muscle tone, circulation, range of motion and address physical symptoms related to a child’s illness.
- 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 is divided into distinct rate codes for the above services, which are found in Appendix B.

6. 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, LDSS/LGU/SPOAs, 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 Respite⁹.

⁹ Subject to additions

Planned Respite Services:

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

Crisis Respite Services:

- Crisis Respite Individual (under 4 hours)
- Crisis Respite Individual (more than 4 hours, less than 12 hours)
- Crisis Respite Individual (more than 12 hours, less than 24 hours)

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

7. Habilitation

Habilitation assists children with developmental, medical or behavioral disabilities acquire a particular skill with the self-help, socialization, and adaptive skills necessary for successful functioning in the home and community. 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:

- Habilitation Individual
- Habilitation Group of 2
- Habilitation Group of 3

Distinct rate codes can be found in Appendix B.

8. 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.

Environmental Modifications

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.

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.

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.

9. 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.

10. 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 Descriptions¹⁰

Other Licensed Practitioner

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
OLP Licensed Evaluation	7900	90791	N/A	TBD	1
OLP Counseling Individual	7901	H0004	N/A	15 Minutes	4
OLP Crisis	7902	H2011	N/A	15 Minutes	8
OLP Crisis Triage (By Phone)	7903	H2011	N/A	15 Minutes	2
OLP Crisis Complex Care	7904	90882	N/A	5 Minutes	4
OLP Counseling Group	7905	H0004	N/A	15 Minutes	4
Offsite – OLP Evaluation	7919	90791	N/A	TBD	1

¹⁰ Subject to additions

Offsite – OLP Counseling	7920	H0004	N/A	TBD	1
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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	N/A	15 Minutes	4
Offsite- CPST	7921	H0036	N/A	TBD	1

Psychosocial Rehabilitation

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
PSR Service Professional	7913	H2017	N/A	15 Minutes	8
PRS Service Professional Group	7914	H2017	N/A	15 Minutes	4

Offsite- PSR	7922	H2017	N/A	TBD	1
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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	N/A	15 Minutes	6
Offsite-FPS/YPS	7923	H0038	N/A	TBD	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	N/A	15 Minutes	6
Offsite-FPS/YPS	7923	H0038	N/A	TBD	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 Descriptions¹¹

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	HR or HS	15 minutes	TBD
Caregiver Family Supports and Services Group of 3	8005	H2014	HR or HS	15 minutes	TBD

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	N/A	Per hour	TBD
Prevocational Services Group of 3	8008	T2015	N/A	Per hour	TBD

Community Advocacy Training and Support

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

Supported Employment

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

Palliative Care

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Palliative Care Pain and Symptom Management	8016	TBD	TBD	per visit	TBD
Palliative Care Bereavement Services	8017	TBD	TBD	per 30 min	TBD
Palliative Care Massage Therapy	8018	TBD	TBD	per 30 min	TBD
Palliative Care Expressive Therapy	8019	TBD	TBD	per 30 min	TBD

Respite- Planned¹²

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Planned Respite - Individual (under 4 hours)	TBD	TBD	N/A	Per Hour	TBD
Planned Respite - Individual per diem	TBD	TBD	N/A	Per Diem	TBD
Planned Respite - Group less than 4 hours	TBD	S5150	N/A	Per Hour	TBD

¹² Subject to additions

Respite- Crisis¹³

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Crisis Respite - Individual less than 4 hours	TBD	TBD	N/A	Per Hour	TBD
Crisis Respite – Individual more than 4 hours less than 12 hours	TBD	TBD	N/A	Per Diem	TBD
Crisis Respite - Individual more than 12 less than 24 hours	TBD	TBD	N/A	Per Hour	TBD

Habilitation

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/day
Habilitation Individual	8012	H2014	N/A	15 minutes	8
Habilitation Group of 2	8013	H2014	N/A	15 minutes	TBD

¹³ Subject to additions

Habilitation Group of 3	8014	H2014	N/A	15 minutes	TBD
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Accessibility Modifications

Service	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit
Accessibility Modifications	8032	E0315	N/A	\$1.00	N/A
Accessibility Modifications	8034	E0315	N/A	\$10.00	N/A
Accessibility Modifications	8035	E0315	N/A	\$100.00	N/A
Accessibility Modifications	8036	E0315	N/A	\$1000.00	N/A
Vehicle Modifications	8041	E0315	N/A	\$1.00	N/A
Vehicle Modifications	8042	TBD	N/A	\$10.00	N/A
Vehicle Modifications	8043	TBD	N/A	\$100.00	N/A
Vehicle Modifications	8044	TBD	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	E0315	N/A	\$1.00	N/A
Adaptive and Assistive Equipment	8038	E0315	N/A	\$10.00	N/A
Adaptive and Assistive Equipment	8039	E0315	N/A	\$100.00	N/A
Adaptive and Assistive Equipment	8040	E0315	N/A	\$1000.00	N/A