



CARELON BEHAVIORAL HEALTH
NEW YORK MEDICAID ADDENDUM

Any policies contained in this Provider Handbook Addendum will supersede those policies contained in Carelon Behavioral Health’s [National Provider Handbook](#). This Addendum is specific to your state. Providers should refer to their plan-specific section within this Addendum.*

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New York Medicaid Addendum

The following chapters referenced below correspond with the chapters found in the Carelon Behavioral Health (Carelon) [National Provider Handbook](#). Information included under each chapter is specific to your Plan.

1. INTRODUCTION

NYS is collaborating with Medicaid Managed Care Organizations (MMCO) to manage the delivery of the expanded Medicaid-covered services for all Medicaid enrolled children. The goal is to fundamentally restructure and transform the health care delivery system for individuals under 21 that have behavioral health needs and/or medical complex conditions.

The goals of the NYS Medicaid redesign for children is to improve health outcomes, control Medicaid costs and provide care management for all Medicaid members that aligns incentives for the provision of high quality. A key feature of the model is to create a community based Medicaid managed care model where there is “no wrong door” for children/youth experiencing complex needs, including children with complex medical needs. NYS envisions a cross-system approach that diminishes silos of care and improves health outcomes for children well into adulthood.

Carelon Behavioral Health (Carelon) is partnering with Health Plans to offer the behavioral health components of these programs.

To support integration and create better health outcomes for children and youth, NYS has taken the following key policy steps to stimulate the transformation:

- NYS will make available, via Medicaid, six new services that were previously not available or were only available to children who met narrow eligibility criteria.
- NYS is establishing level of care (LOC) and level of need (LON) criteria to identify subpopulations of children who are likely to benefit from an array of home- and community-based services (HCBS). The LON subpopulation will identify children prior to needing institutional care or as a step down from LOC. This population is at risk by virtue of exposure to adverse events or symptoms leading to functional impairments in their home, school or community. (Attachment A and Attachment B reflect eligibility criteria for LOC and LON designations respectively).
- NYS is simplifying six existing children’s 1915(c) waivers into one integrated array of HCBS for an expanded number of Medicaid eligible children allowing them to stay in their home communities to avoid residential and inpatient care.

Health Home Care Management for Children

Concurrent with managed care carve-in, children eligible for HCBS will be enrolled in Health Homes. The care coordination of service of the children's HCBS will transition to Health Home unless the child opts out of the Health Home. Health Homes will administer all HCBS assessments through the Uniform Assessment System which will have algorithms (except for the foster care developmentally disabled (DD) and OPWDD care at home medical fragile developmentally disabled (CAH MF) populations) to determine functional eligibility criteria for HCBS.

Via a phased approach, the following services will be managed under Medicaid managed care:

- Children's HCBS
- Outpatient addiction services
- Residential addiction services
- Licensed behavioral health practitioners
- Other Licensed Practitioner (OLP)
- Crisis Intervention
- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation Services (PSR)
- Family Peer Support Services
- Youth peer support and training

To facilitate a smooth transition for children in receipt of HCBS, MMCOs will begin accepting POCs per the NYS Timeline for the following:

- a) MMCO enrolled population or a child for whom the Health Home Care Manager or Independent Entity has obtained consent to share the POC with the Plan and the family has indicated that the Plan selection process has been completed; and
- b) A child in the care of a LDSS/licensed VFCA, where Plan election has been confirmed. The Plan will continue to accept POC for children in receipt of HCBS in advance of the effective date of enrollment when the Plan is notified by another Plan, a Health Home Care Manager or the Independent Entity that there is consent to share the POC with the Plan and the family has demonstrated the Plan selection process has been completed, or for a child in the care of a LDSS/licensed VFCA, Plan selection has been confirmed by the LDSS/VFCA.

2. ELECTRONIC RESOURCES

See Carelon national handbook

3. PARTICIPATING PROVIDERS

Medicaid Provider Designation

In order to provide services to eligible individuals, a program must be designated by NYS to provide a specific service and contracted by Carelon to provide that service.

For behavioral health designated providers, Carelon will ask for an application and service attestation to be filled out to collect the information necessary to complete plan integrity checks and ensure individuals and organizations are not excluded by Medicare or Medicaid. Carelon will conduct the following checks:

- National Practitioner Data Bank (NPDB)
- OIG Exclusion
- OMIG Exclusion
- SAM Exclusion
- New York DOH HCBS Designation List Check

State designation of providers will suffice for the Carelon's credentialing process. When contracting with NYS-designated providers, Carelon may not separately credential individual staff members in their capacity as employees of these programs.

Home and Community Provider Designation

In order to provide HCBS to Carelon eligible individuals, a program must be designated by NYS to provide a specific service and contracted by Carelon to provide that service.

For behavioral health HCBS designated providers, Carelon will ask for an application and HCBS service attestation to be filled out to collect the information necessary to complete plan integrity checks and ensure individuals and organizations are not excluded by Medicare or Medicaid. Carelon will conduct the following checks:

- NPDB
- OIG Exclusion
- OMIG Exclusion
- SAM Exclusion
- New York DOH HCBS Designation List Check

State designation of BH HCBS providers will suffice for Carelon's credentialing process. When contracting with NYS-designated BH HCBS providers, Carelon may not separately credential individual staff members in their capacity as employees of these programs. Carelon must still conduct program integrity reviews to ensure

that BH HCBS provider staff are not disbarred from Medicaid or any other way excluded from Medicaid reimbursement.

Providers of Home and Community Based Services (HCBS) to children under 21 years of age authorized under the Children's 1115 Waiver amendment are required to conduct Criminal History Record Checks (CHRC), including finger printing, on prospective employees and Statewide Central Register (SCR) Database Checks on prospective employees. State training materials outlining the requirements may be found at

www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index

OMH-Licensed and OASAS Certified Behavioral Health Providers

When credentialing OMH-licensed, OMH-operated, and OASAS-certified providers, Carelon will accept OMH and OASAS licenses and certifications in place of the credentialing process for individual employees, subcontractors or agents of such providers. Carelon collect and will accept program integrity related information as part of the licensing and certification process.

Carelon requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

4. CREDENTIALING AND RE-CREDENTIALING

See Carelon national handbook

5. OFFICE PROCEDURES

See Carelon national handbook

6. SERVICES TO MEMBERS

- I. Behavioral Health Benefits for all Medicaid Populations Managed Under 21
 - Assertive Community Treatment (ACT)
 - Youth Assertive Community Treatment (ACT)- minimum age is 10-21 for the child population
 - Community First Choice Option (CFCO) State Plan Services for Children meeting eligibility criteria
 - Children's Day Treatment
 - Comprehensive Psychiatric Emergency Program including Extended Observation Bed
 - Continuing Day Treatment-minimum age is 18 for medical necessity for this adult oriented service
 - Health Home Care Management
 - Intensive Outpatient Program- minimum age is 13 years
 - Inpatient Psychiatric Services (OMH service)
 - Licensed Behavioral Health Practitioner (LBHP) Service
 - Licensed Outpatient Clinic Services (OMH services)
 - Medically-Managed Detoxification (hospital-based) (OASAS service)
 - Medically-Supervised Inpatient Detoxification (OASAS Service)
 - Medically-Supervised Outpatient Withdrawal (OASAS services)
 - OASAS Inpatient Rehabilitation Services
 - OASAS Outpatient and Residential Addiction Services
 - OASAS Outpatient Rehabilitation Programs
 - OASAS Outpatient Services
 - OMH State Operated Inpatient
 - Other Licensed Practitioner (OLP)
 - Partial Hospitalization
 - Outpatient Clinic and Opioid Treatment Program (OTP) services (OASAS services)
 - Personalized Recovery Oriented Services (PROS)-minimum age is 18 for medical necessity for this adult oriented service
 - Rehabilitation Services for residents of community residences
 - Residential Rehabilitation Services for Youth (RRSY)
 - Residential supports and services (Early Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)
 - Residential Treatment Facility (RTF)

Additional Services for Children and Targeting and Functional Needs

- Caregiver/Family Advocacy Training Supports
- Children's State Plan Amendment Crisis Intervention Demonstration Services
- Community Psychiatric Support and Treatment (CPST)
- Family Peer Support Services
- Youth Peer Support and Training
- Habilitation (including habilitative skill-building)
- Non-medical transportation
- Other Licensed Practitioner
- Peer Supports
- Planned Crisis
- Prevocational Services
- Psychosocial Rehabilitation Supports
- Respite
- Supported Employment
- Teaching Family Home

A description of the new State Plan benefits may be found in the current [State Plan Services Manual](#). The HCBS benefits are listed below (additional detail can be found in the current [HCBS Provider Manuals and Rates](#)).

Children currently treatment at the time of benefit transition, may continue with their current care providers, including medical, behavioral health, and HCBS providers, for a continuous episode of care. Continuity of care will be in place for the first 24 months of the transition and it applies only to episodes of care that were ongoing during the transition period from fee-for-services to managed care.

II. Children and Family Treatment Support Services (CFTSS)

Other Licensed Practitioner

Non-physician licensed behavioral health practitioner (NP-LBHB) who is licensed in the State to prescribe, diagnose, and/or treat individuals with a physical, mental illness, substance use disorder, or functional limitations at issue, operating within the scope of practice defined in State law and in any setting permissible under State practice law (i.e., services can be delivered in the community outside the four walls of the agency). NP-LBHPs include individuals licensed and able to practice independently or are under the supervision or directions of a licensed clinical social worker, a licensed psychologist, or a psychiatrist. Activities would include:

- Recommending treatment that also considers trauma-informed, cultural variables, and nuances
- Developing recovery or treatment plan
- Activities within the scope of all applicable state laws and their professional license including counseling, individual, or family therapy
- Developing recovery oriented treatment plans

Crisis Intervention

Crisis intervention services are provided to 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.

Community Psychiatric Support & Treatment (CPST)

Community Psychiatric Support & Treatment (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. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community-based onsite rehabilitative services.

Psychosocial Rehabilitation

Psychosocial Rehabilitation Services (PRS) are designed to work with children and their families to implement interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or environment barriers associated with a child/youth's behavioral health needs.

Family Peer Support Services

Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community. FPSS provided a structure, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/ caregiver for the benefit of the child/ youth.

Youth Peer Support and Training

Youth Peer Support and Training (YPST) services are formal and informal services and supports provided to youth and families raising an adolescent who is 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 process.

- III. 1915i Home- and Community-Based Services Review Guidelines and Criteria Home- and Community-Based Services (HCBS) provide opportunities for Medicaid beneficiaries under 21 that have behavioral health needs and/or medically complex conditions to receive services in their own home or community. Implementation of HCBS will help to create an environment where managed care plans (Plans), Health Home Care Managers, CYES Case Managers (Independent Entity) service providers, plan members, and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and improve health outcomes.

All eligible members that consent will be linked to a local Health Home or CYES, if opting out of Health Home, for care coordination. Health Home care management is provided by the assigned community mental health agency The Plan, in partnership with the Health Home or CYES and HCBS providers, ensures medical and behavioral health care coordination and service provision for its members. The Plan will collaborate with Carelon to oversee and support CYES or Health Homes and HCBS providers via identified quality and utilization metrics and clinical review to ensure adherence with program specifications as defined by NYS-established criteria. The program oversight includes effectively partnering and engaging with contracted Health Home and HCBS providers to ensure that program operations and service delivery have a consistent focus on key factors that result in quality and efficacious treatment for eligible enrollees.

All eligible members will additionally be assigned a Carelon Care Manager who will serve at the contact with the Health Home/CYES will review clinical information, and will collaborate on coordination of care, as appropriate.

These review guidelines provide a framework for discussion between HCBS providers and Health Plans. The review process is a collaboration between all pertinent participants including but not limited to the Health Home Care Manager or CYES Care Manager HCBS provider, Plan, and member to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the members chosen goals. These conversations will focus on the member's needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all members. In general, services will be authorized if they meet the specific criteria for a particular service. The individual's needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

Health Home Care Managers or CYES will determine eligibility for HCBS using a standard needs assessment tool. Procedures for authorizing specific HCBS include:

1. If the member is eligible for HCBS, the Health Home Care Manager or CYES Care Manager will complete an assessment that includes documentation of the member's needs, strengths, goals, and preferences.
2. In collaboration, the member and Health Home Care Manager or CYES Care Manager will develop a comprehensive and person-centered plan of care. The plan of care will reflect the member's assessed and self-reported needs, as well as those identified through claims review and case conference with providers when appropriate.
3. The Health Home Care Manager or CYES Care Manager will share results of the HCBS assessment and plan of care with the Plan for review and feedback.
4. If the member is enrolled with the Health Home, the Health Home will link the member with an HCBS provider. If the member is not enrolled with the Health Home, CYES or the Plan will link the member to the HCBS provider. Members will be offered a choice of HCBS providers from within the Plan's network.
5. HCBS provider(s) will conduct service specific assessment(s) and forward additional information to Health Home Care Manager or CYES Care Manager regarding intensity and duration of services. The Health Home Care Manager or CYES Care Manager will update the Plan with HCBS provider-specific information and present it to the MCO for review.
6. HCBS providers will be required to submit a notification to the Plan when a member has been accepted. The notification must be made before the member begins to receive HCBS. The HCBS and/or CMA provider will present the member's plan of care to the Plan for review. Notification will allow for authorization of specific HCBS interventions as well as collaborative monitoring to assure timely and appropriate care coordination. Plan utilization management will ensure the member's plan of care reflects the member's individual, assessed, and self-reported needs and is aligned with concurrent review protocols.

Health Home outcome data and analytics including member's level of care, adequacy of service plans, provider qualifications, member health and safety, financial accountability, and compliance will be collected in partnership between Carelon and the Plan. Data will be aggregated from various sources including the Medicaid Analytic Provider Portal and from review of claims/utilization.

The following is a description of the various HCBS services. These services should be provided using the principles of recovery orientation, person-centeredness, strengths-based, evidence-based, and delivered in the community and the most integrated settings whenever possible.

IV. Health Homes and Home and Community Based Services (HCBS)
Carelon collaborates with the Plan's Health Homes and provides oversight of the HCBS plan of care process as it relates to behavioral health service integration. If member is not enrolled in Health Home, Carelon collaborates with CYES for recertification of HCBS but maintains coordination of the Plan of Care for member. This collaboration includes, but is not limited to:

- Assurance of integrated and person-centered approaches to medical and behavioral health coordination of care via cross-discipline professional collaboration between the Health Homes,
- HCBS providers, CYES and the Plan aimed at optimizing health outcomes for members
- Management of members with complex health needs, co-morbid conditions, and/or high-cost by ensuring timely communication between providers, exchange of treatment goals, plans of care, and progress information, in addition to encouraging innovation and creativity in joint problem solving
- Carelon and/or the Plan assigns internal clinical staff to liaise with the Health Home or CYES and HCBS service providers to support the plan of care process
- Assurance of completion of the comprehensive screening by the Health Home Care Coordinator or other qualified assessor to identify areas of need, short-term goals, and long-term goals. Screening includes identification of members who would benefit from HCBS services
- Assurance that assessment and subsequent plan of care includes unmet health needs, medication adherence, self-management skills and training, healthy living choices, and coordination of complex medical and behavioral care
- Assurance of annual re-evaluation of the plan of care (or re-evaluation due to change in status or adverse event) to measure the effectiveness of interventions in improving member outcome and quality of life as well as reducing adverse incidents or risk
- Analysis and data sharing with Health Homes regarding utilization data to identify trends of overuse in emergency department and inpatient admissions, while collaborating to develop a tailored strategy to reduce the number of inappropriate or unnecessary admits
- Carelon collaborates with our plan partners to work with providers to collect accurate baseline data. Provider profiles are shared with providers, Health Homes, and any other appropriate stakeholders in an effort to continuously improve clinical service delivery and health outcomes.
- In collaboration with the Plan, Carelon utilizes the level of care criteria sanctioned by NYS. Individual preferences and presence of functional impairment justify medical necessary criteria. Any resource allocation rules are followed by Carelon and the Plan.

- As appropriate, Carelon, in collaboration with the Plan, supports the State in building capacity in Health Homes by:
 - Utilizing standard reporting measures on cost and quality that tie behavioral health and medical financial, clinical, and member satisfaction outcomes together.
 - Completing network analyses in conjunction with the health plan to identify Health Homes and providers best suited for managing individuals with serious mental illness (SMI) or functionally limiting substance use disorders
- Carelon collaborates with the Plan to ensure that the NYS-established medical necessity criteria for each HCBS, as well as member's goals and preferences, will weigh into decisions made regarding services, but the regular medical necessity criteria will not apply (i.e., does not require active symptoms, the individual's preference and the presence of functional impairment is enough to support need when a medical order is not necessary).

HCBS services are only available to enrollees qualified through the assessment process and eligible individuals enrolled in HIV-SNPs and assessed as HCBS eligible. A mainstream plan may provide HCBS to its enrollees as a cost effective alternative to regular OMH and OASAS licensed/certified services (on an in lieu of basis and paid by the Mainstream plan from its capitation rate). In order to be reimbursable, services rendered, including scope and duration must be part of an approved personalized recovery plan.

For children transitioning from a 1915(c) waiver, the Plan must continue to authorize covered HCBS and LTSS in accordance with the most recent plan of care for at least 180 days following the date of transition of children's specialty services newly carved into managed care. Service frequency, scope, level, quantity, and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new plan of care is to be developed.

- During the initial 180 days of the transition, the Plan will authorize any children's specialty services newly carved into managed care that are added to the plan of care under a person-centered process without conducting utilization review.

- V. Respite (Planned and Crisis)
Respite focuses on short-term assistance and/or relief for children with disabilities (developmental, physical and/or behavioral), and family/ caregivers which can be provided in a planned mode or delivered in a crisis environment. To the extent that the skilled nursing is provided as a form of respite, this service has to be ordered by a physician. This service may be provided in a one-to-one, individual session, or group session. The need for crisis respite may be identified as a result of a Medicaid State Plan crisis intervention or may come from referrals from the emergency room, the community, LDSS/LGU/SPOA, school, self-referrals, or as part of a step-down plan from an inpatient setting. Crisis respite should be included on the plan of care to the extent that it is an element of the crisis plan or risk mitigation strategy.
- VI. Caregiver / Family Support Services
Caregiver/Family Supports and Services and Community Self-Advocacy Training and Supports enhance the child/youth's ability, regardless of disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community as well as, provides the child/youth, family, caregivers, and collateral contacts (family members, caregivers, and other stakeholders identified on the child/youth's POC) with techniques and information not generally available so that they can better respond to the needs of the participant. These services are intended to assist the child/youth, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their disability (ies). These services can enhance the child/youth's ability, regardless of disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community.
- VII. Prevocational Services
Prevocational services are individually designed to prepare a youth age 14 or older to engage in paid work, volunteer work or career exploration. Prevocational services are structured around teaching concepts such as compliance, attendance, task completion, problem solving, and safety based on a specific curriculum related to youth with disabilities (developmental, physical, and/or behavioral). In addition, prevocational services assist facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements. Prevocational services are not job-specific, but rather are geared towards facilitating success in any work environment for children whose disabilities do not permit them access to other prevocational services. The service will be reflected in a participant's service plan directed to teaching skills rather than explicit employment objectives.

- VIII. Supportive Employment
Supported employment services are individually designed to prepare individuals with disabilities (developmental, physical, and/or behavioral) age 14 and older to engage in paid work. Supported employment services provide assistance to participants with disabilities as they perform in a work setting. Supported employment provides ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in a competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.
- IX. Habilitation (Community and Day)
These services focus on helping children with developmental, medical, and behavioral disabilities who are eligible for HCBS to be successful in the home, community, and school by acquiring both social and environmental skills associated with his/her current developmental stage. Habilitation services assist children who have never acquired a particular skill with the self-help, socialization and adaptive skills necessary for successful functioning in the home and community when other types of skill-building services are not appropriate. Habilitation covers in-person services and supports related to the child/youth's acquisition, maintenance, and enhancement of skills necessary to perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and/or Health-Related Tasks delivered in the community (non-certified) settings. This service may be delivered in an individual or group setting. Habilitation is provided to the child and the child's family/caregiver to support the development and maintenance of skill sets.
- X. Crisis Residence Programs
Crisis Residence Programs are licensed and regulated pursuant to OMH Part 589 regulations: [part589-text.pdf \(ny.gov\)](#). The 3 OMH licensed Crisis Residence Programs are:
- A. Children's Crisis Residences (Under 21)
 - B. Residential Crisis Support (18 and over)
 - C. Intensive Crisis Residence (18 and over)

A. Children's Crisis Residences (Under 21)

Children's Crises Residence Programs serve children under age 21. The length of stay anticipated of 21 days; maximum of 28 days, unless approved by MMCPs for enrollees. There is a maximum of 8 beds, no minimum. The program will ensure linkages and connections to community based services, medication management (if needed), and provide counseling related to the crisis situation that resulted in the admission. Wherever possible, children are expected to attend their school, continue the services they have received in the community and engage in new services (if needed) to prevent an escalation of symptoms. Children actively receiving services at a Crisis Residence may not receive duplicative behavioral health services in the community; however, they may begin or continue mental health services to ensure continuity of care or discharge planning goals. Treatment in the crisis residence will focus on the crisis situation which prompted admission to the program and be consistent with any crisis or mental health treatment plan already in effect for the child and their behavioral health needs.

B. Residential Crisis Support (18 and over)

The residential crisis support program provides voluntary, short term residential crisis support services to individuals experiencing a mental health crisis or challenges in daily life that create a risk for an escalation of symptoms that cannot be managed in the individual's home and community without onsite supports. Individuals do not need a diagnosis to receive or for MMCPs to reimburse for services. Individuals can receive Residential Crisis Support services for up to 28 days. Residential Crisis Support Programs have between 3-16 beds. Peer support is a critical component of this program. Adult BH HCBS Short term respite providers will be included in this category.

C. Intensive Crisis Residence (18 and over)

A voluntary short term residential treatment service for individuals experiencing a mental health crisis to evaluate, resolve and/or stabilize crisis symptoms. There must be identified treatment needs. The program can address co-occurring conditions. The individual must have a primary mental health diagnosis for reimbursement by Medicaid Managed Care. Individuals can receive Intensive Crisis Residence services for up to 28 days. Intensive Crisis Residence Programs have between 3 and 16 beds and an interdisciplinary treatment team which included Licensed Professionals, Para Professionals and NYS Certified Peers.

7. MEMBER RIGHTS AND RESPONSIBILITIES

See Carelon national handbook

8. PARTICIPATING PROVIDER COMPLAINTS AND GRIEVANCES

See Carelon national handbook

9. CLAIMS PROCEDURES

Assertive Community Treatment (ACT)

ACT services are billed once per month using one rate code for the month's services. There are three types of monthly payments which are dependent on the number and type of contacts with the recipient or collaterals: full, partial or inpatient. Claims are submitted using the last day of the month in which the services were rendered as the date of service. A contact or Unit of Service is defined as a face-to-face interaction of at least 15 minutes duration where at least one ACT service is provided between an ACT team staff member and the recipient or collateral. Providers should use the per diem code, with number of contacts during month in the unit field.

ACT Reimbursement and Billing Changes

Effective January 1, 2025, NYS implemented changes to Youth ACT billing requirements. Youth ACT teams will no longer submit claims using rate codes 4508, 4509 and 4511. ACT teams will be required to utilize new youth rate codes 4153, 4514, 4515 and their associated procedure codes and modifiers. Please see the grids below for reference. Also note that for Adult ACT there are no rate code changes. For both Children and Adult ACT services, providers will be required to bill with the appropriate number of units.

Youth:

Rate Code	Service	Procedure Code	Modifiers	Units
4513	Youth ACT Intensive Full Payment	H0040	HA	6
4514	Youth ACT Intensive Part Payment	H0040	HA, U5	2-5
4515	Youth ACT Inpatient	H0040	HA, HK	2+

Note: For all rate codes/proc code/mod combinations, report number of contacts for the month in the units field.

Adult:

Rate Code	Service	Procedure Code	Modifiers	Units
4508	Adult ACT Intensive Full Payment	H0040		6
4509	Adult ACT Intensive Part Payment	H0040	U5	2-5
4511	Adult ACT Inpatient	H0040	U1, U5	2+

Note: For all rate codes/proc code/mod combinations, report number of contacts for the month in the units field.

OMH-Licensed Clinic, OASAS-Certified Clinic, OASAS-Certified Opiate Treatment Clinic, and OASAS Certified Outpatient Rehabilitation

OMH Clinics, both hospital-based and freestanding, will continue to bill with APG methodology using rate code, procedure code, and modifier code combinations in place since September 1, 2012.

- OASAS-Certified Clinic
- OASAS Outpatient Programs
- OASAS-Certified Opiate Treatment Clinic
- OASAS Certified Outpatient Rehabilitation

Outpatient Programs

Outpatient services are professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized non-residential treatment setting. Outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure standards. All outpatient substance use disorder programs are certified under OASAS Regulation in accordance with Mental Hygiene Law.

These services include, but are not limited to individual, group, family counseling including psycho education on recovery, and wellness. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity but are fewer than nine contact hours per week. New York State LOCADTR criteria are used to determine level of care. In New York, these are delivered in/by OASAS outpatient settings Certified by Title 14 NYCRR Part 822

Opioid Treatment Programs

OTPs are federally regulated programs that include direct administration of daily medication (opioid agonists: methadone or buprenorphine or antagonists following a successful agonist taper: naltrexone and vivitrol) as well as a highly structured psychosocial program that addresses major lifestyle, attitudinal, and behavioral issues that could undermine recovery-oriented goals. The participant does not have a prescription for the methadone or buprenorphine, but receives daily medication from the OTP. In New York, OTPs are certified by OASAS under Title 14 NYCRR Part 822.

Outpatient Rehabilitation

Chemical dependence outpatient rehabilitation services (outpatient rehabilitation services) are services provided by an outpatient program which has been certified by OASAS to provide outpatient rehabilitation services; such services are designed to assist individuals with more chronic conditions who are typically scheduled to attend the outpatient rehabilitation program three to five days per week for at least four hours per day. (Part 822.15 (i)) outpatient rehabilitation services for individuals with more chronic conditions emphasize development of basic skills in prevocational and vocational competencies, personal care, nutrition, and community competency. These services are provided in combination with all other clinical services provided by outpatient programs. If an outpatient program is providing outpatient rehabilitation services, the following services must be available either directly or through written agreements: (1) socialization development; (2) skill development in accessing community services; (3) activity therapies; and (4) information and education about nutritional requirements, including but not

limited to planning, food purchasing, preparation and clean-up. (e) A provider of outpatient rehabilitation services must assure the availability of one meal to each patient who receives outpatient rehabilitation services for four or more hours per day (Part 822.15 (a) (d) (e)). In New York these are delivered in OASAS outpatient settings Certified by Title 14 NYCRR Part 822.

OASAS Rate Codes

Providers will input 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" and following that immediately with the appropriate four-digit rate code. This is the standard mechanism currently used in Medicaid fee-for-service billing.

Rate Codes: Once the claim is received the plan will utilize the rate code for MEDS reporting. Rate codes are assigned based upon certification/program type and setting (hospital vs freestanding).

CODE TABLE	RATE CODE (SAME AS APG RATE CODE)
Title 14 NYCRR Part 822 Hospital Based OASAS Certified Outpatient	
Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Clinic Program	1528
Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Rehab Program (to be added to grouper at a later date)	1561
Part 822 Hospital (Art 28 and Art 32) Opiate Treatment Program	1567
Medical Services	
Part 822 Hospital (Art 28/ 32) Chemical Dependence Outpatient Program	1552
Part 822 Hospital (Art 28/32) Chemical Dependence Outpatient Rehab Program (to be added to grouper at a later date)	1558
Part 822 Hospital (Art 28/32) Opiate Treatment Program	1555
Title 14 NYCRR Part 822 Community/Freestanding	
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Clinic Program	1540
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Rehab Program	1573
Part 822 Community (Art 32 only) Opiate Treatment Program	1564
Medical Services	
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Program	1468
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Rehab Program	1570
Part 822 Community (Art 28/32) Opiate Treatment Program	1471

Continuing Day Treatment (CDT)

CDT services are billed on a daily basis. The rates of reimbursement are separated into three tiers:

1. 1-40 hours
2. 41-64 hours
3. 65+ hours

These three tiers span across two types of visits: full-day (four hours minimum) and half-day (two hours minimum). Tiers are determined by totaling the number of full-day and half-day regular visits, based on their hour equivalents. As the hours accumulate throughout the month, the provider will need to move from one tier to another to bill. Each subsequent tier has a decline in payment. Providers must keep track of the number of hours of service provision in order to know what rate code (tier) should be billed.

When the program hours of any single visit include more than one tier, the provider of service will be reimbursed at the tier that applies to the first hour of that visit. Each CDT service tier has a unique combination of rate code/procedure code/modifier code(s), as indicated on the crosswalk below.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OF SERVICE
4310	CDT Half Day 1- 40	H2012	Behavioral Health Day Treatment, per hour	U1, U5	2-3
4311	CDT Half Day 41-64	H2012	Behavioral Health Day Treatment, per hour	U2, U5	2-3
4312	CDT Half Day 65+	H2012	Behavioral Health Day Treatment, per hour	U3, U5	2-3
4316	CDT Full Day 1- 40	H2012	Behavioral Health Day Treatment, per hour	U1	4-5
4317	CDT Full Day 41-64	H2012	Behavioral Health Day Treatment, per hour	U2	4-5

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OF SERVICE
4318	CDT Full Day 65+	H2012	Behavioral Health Day Treatment, per hour	U3	4-5
4325	CDT Collateral	H2012	Behavioral Health Day Treatment, per hour	UK	1
4331	CDT Group Collateral	H2012	Behavioral Health Day Treatment, per hour	UK, HQ	1
4337	CDT Crisis	H2012	Behavioral Health Day Treatment, per hour	U8	1
4346	CDT Pre-Admission	H2012	Behavioral Health Day Treatment, per hour	U9	1

CPEP

CPEP is claimed on a daily basis. A patient may receive one brief or one full emergency visit service in one calendar day. If a patient receives one of each, the CPEP will receive reimbursement for the full emergency visit. A provider may be reimbursed for either one crisis outreach service or one interim crisis service and either one brief or one full emergency visit per recipient, per one calendar day. If more than one service is provided, then more than one claim must be submitted (one claim for each rate code).

Each CPEP service has a combination of rate code/procedure code/modifier code indicated on the crosswalk below. CPEP does not require prior authorization and a patient should receive access to services immediately upon presentation at a service delivery site.

Claiming for Extended Observation Beds:

- Admission to the extended observation bed is, for billing purposes, the calendar day after the calendar day in which the full or brief visit is completed.
- The extended observation bed rate may only be claimed when a person has been held in the CPEP for more than 24 hours.
- A brief or full visit claim is submitted for the calendar day in which the visit is completed, and claims for the extended observation bed are submitted for each subsequent day, up to 72 hours from the patient's initial arrival in the CPEP.
- If the patient is admitted to the psychiatric inpatient unit, the extended observation bed rate is not claimed. The psychiatric inpatient unit rate is claimed instead beginning on admission to the extended observation bed

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4007	Brief Evaluation	90791	Psych Dx Evaluation	HK, U5	1	Billed on a daily basis
4008	Full Evaluation	90791	Psych Evaluation	HK	1	Billed on a daily basis
4009	Crisis Outreach Visit	S9485	Crisis Intervention Mental Health Services, per diem	HK	1	These are services provided outside an ER setting. Code also pays in HCBS and APGs so use the HK modifier to differentiate the claim. Billed daily.
4010	Interim Crisis Visit	H0037	Community Psych Support Treatment Program, per diem	HK	1	These are services provided outside an ER setting. Code also pays in HCBS and APGs so use the HK modifier to differentiate the claim. Billed daily.
4049	Extended Observation					See Notes above

Partial Hospitalization

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4356	Partial Group Collateral - 2 Hours	H0035	Mental Health Partial Hosp. Treatment under 24 Hours	U2, HQ, HR or HS	2	Billed daily. Code with 2 units. Use HQ (group) modifier. Also use HR or HS modifier (in addition to HQ and U2). This code does not pay in APGs.
4357	Partial Hospitalizati on Crisis - 1 Hour	S9484	Crisis Intervention per hour	HK, U1, [UA]	1	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily. Add the UA modifier if the service is a pre- admission.
4358	Partial Hospitalizati on Crisis - 2 Hours	S9484	Crisis Intervention per hour	HK, U2, [UA]	2	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily. Add the UA modifier if the service is a pre- admission.
4359	Partial Hospitalizati on Crisis - 3 Hours	S9484	Crisis Intervention per hour	HK, U3, [UA]	3	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily. Add the UA modifier if the service is a pre- admission.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4360	Partial Hospitalization Crisis – 4 Hours	S9484	Crisis Intervention per hour	HK, U4	4	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily.
4361	Partial Hospitalization Crisis – 5 Hours	S9484	Crisis Intervention per hour	HK, U5	5	Pays in APGs. Use HK modifier to differentiate claim. Billed daily.
4362	Partial Hospitalization Crisis – 6 Hours	S9484	Crisis Intervention per hour	HK, U6	6	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily.
4363	Partial Hospitalization Crisis – 7 Hours	S9484	Crisis Intervention per hour	HK, U7	7	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily.

Personalized Recovery Outcome Services (PROS)

Members over 18 years of age might be eligible for PROS services. A comprehensive PROS program is reimbursed on a monthly case payment basis. PROS claims use the last day of the month as the date of service and that date represents all the days for that month. Therefore, all the line level dates of service must also be the last day of the month. Each unique procedure code/modifier code(s) combination should be recorded on its own claim, along with the corresponding units of service and the pre-managed care rate code in the header of the claim.

In addition to the monthly case payment, PROS providers are also reimbursed for three component add-ons: Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS), and Clinic Treatment services. Up to two component add-ons may be billed per individual, per month. In no event will an ORS component add-on and an IR component add-on be billed in the same month for the same individual. Component add-ons are not billed prior to the calendar month in which the individual is registered with the PROS program.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4510	PROS Preadmission	H0002	Behavioral Health Screening, Admission Eligibility	HE	1	Billed monthly. The PROS units for the month are determined by using the "PROS Unit Conversion Chart" on a daily basis and then totaling for the month. Use the per diem code and show total PROS units for the month. The number of units coded does not affect payment, as payment is the same throughout the range.
4520	PROS Community Rehab Services, 2-12 units	H2019	Ther Behav Service, per 15 min	U1	2-12	Billed monthly. The PROS units for the month are determined by using the "PROS Unit Conversion Chart" on a daily basis and then totaling for the month. Use the per diem code and show total PROS units for the month. The number of units coded does not affect payment, as payment is the same throughout the range.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4521	PROS Community Rehab Services, 13- 27 units	H2019	Ther Behav Service, per 15 min	U2	13-27	Billed monthly. The PROS units for the month are determined by using the "PROS Unit Conversion Chart" on a daily basis and then totaling for the month. Use the per diem code and show total PROS units for the month. The number of units coded does not affect payment, as payment is the same throughout the range.
4522	PROS Community Rehab Services, 28- 43 units	H2019	Ther Behav Service, per 15 min	U3	28-43	Billed monthly. Requires at least 2 units of PROS in the CRS base (billed on separate line using H2019 - and showing total PROS units for the month). The two "base" units could include CRS, Clinic, Intensive Rehab, or ORS. Show only 1 unit on this line.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4523	PROS Community Rehab Services, 44 - 60 units	H2019	Ther Behav Service, per 15 min	U4	44-60	Billed monthly. Requires at least 6 units of PROS in the CRS base (billed on separate line using H2019 - and showing total PROS units for the month). These two "base" units could include CRS, Clinic, Intensive Rehab, or ORS. Show only 1 unit on this line.
4524	PROS Community Rehab Services, 61+ units	H2019	Ther Behav Service, per 15 min	U5	61+	Requires at least 2 units of PROS in the CRS base (billed on separate line using H2019 - and showing total PROS units for the month). These two "base" units could include CRS, Clinic, IR, or ORS. Show only 1 unit on this line.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4525	PROS Clinical Treatment Add-on	T1015	Clinic Visit/Encounter, All Inclusive	HE	1	Billed monthly. Used instead of rate code 4510, but only for the BIP population. Limited to 4 (instead of only 2) consecutive months. Cannot be billed in same month as PROS monthly base rate services code or other PROS rate codes. This code pays in APGs. Use HE modifier to differentiate claim from clinic (APGs).
4526	PROS Int. Rehab	H2018	Psysoc Rehab Service, per diem	HE	1	This is a monthly add-on to the base rate and can be billed in combination with other add-ons. Two or three services are required (see billing manual), but use one (1) as the billing unit.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4534	Intensive Rehab - AH/NH/PC	H2018	Psysoc Rehab Service, per diem	UB, HE	1	This code is used in place of 4526 for the BIP population. The billing requirements are the same as 4526, but also include the UB modifier.

OASAS Residential Treatment

This setting provides medical and clinical services including: medical evaluation, ongoing medication management and limited medical intervention, ancillary withdrawal and medication assisted substance use disorder treatment, psychiatric evaluation and ongoing management, group, individual and family counseling focused on stabilizing the patient and increasing coping skills until the patient is able to manage feelings, urges and craving, co-occurring psychiatric symptoms and medical conditions within the safety of the residence. All programs are certified under OASAS regulation Title 14 NYCRR Part 820 Part in accordance with Art 32 of the New York State mental hygiene law. Patients should receive an appointment immediately for inpatient substance use detoxification and within 24 hours for inpatient rehabilitation services, stabilization treatment services, substance use disorder outpatient and opioid treatment programs.

Rehabilitation Services in a Residential Setting

In this setting medical staff is available in the residence however, it is not staffed with 24-hour medical/nursing services. This setting provides medical and clinical services including: medical evaluation, ongoing medication management and limited medical intervention, medication assisted substance use treatment when medically necessary, psychiatric evaluation and ongoing management, group, individual and family counseling focused on rehabilitation and increasing coping skills until the patient is able to manage feelings, urges and craving, co-occurring psychiatric symptoms and medical conditions within the community.

Treatment includes structured treatment including individual, group and family counseling. Programs are characterized by their reliance on the treatment community as a therapeutic agent. It is also to promote abstinence from substance use and interpersonal behaviors to effect a global change in participants' lifestyles, attitudes, and values. Individuals typically have multiple functional deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values. LOCADTR criteria are used to determine level of care.

Residential Supports and Services: Early Periodic Screening, Diagnostic and Treatment (EPSDT)

Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventative, dental, mental health, developmental and specialty services.

Residential Treatment Facility (RTF)

A 24hour per day inpatient treatment program which provides intensive treatment services to children and adolescents aged 5-21 who need longer term treatment than would be provided on an inpatient psychiatric program operated by general, private mental hospital, or state psychiatric center.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
1144	Stabilization per diem	H2036	Alcohol and/or Other Drug Treatment Program, per diem	TG, HF	1 / day	Daily Per Diem associated with treatment services delivered to patients within an OASAS Certified Residential Stabilization Program. The per diem excludes room and board.
1145	Rehabilitation per diem	H2036	Alcohol and/or Other Drug Treatment program, per diem	HF	1 / day	Daily Per Diem associated with treatment services delivered to patients within an OASAS Certified Residential Rehabilitation Program. The per diem excludes room and board.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
1146	Reintegration per diem	H2034	Alcohol and/or Drug Halfway House Services, per diem	HF	1 / day	Daily Per Diem associated with treatment services delivered to patients within an OASAS Certified Re- Integration Program. The per diem excludes room and board.

Patient specific annual limitations exist for HCBS services. The proposed limits consist of three elements including:

1. Patient-specific Tier 1 limit of \$8,000. Tier I services include employment, education and peer supports services.
2. Patient-specific overall HCBS (i.e., Tier 1 and Tier 2 combined) limit of \$16,000
3. Short-term crisis respite and intensive crisis respite are individually limited to 7 days per episode and 21 days per year.

When submitting claims for approved waiver program services:

- Claims should be submitted on a UB04 form or 837I file.
- Providers must enter a diagnosis code when submitting claims for all waiver services.
- Providers are required to use the most current, most specific diagnosis code when submitting their claims.

Children and Family Treatment and Support Services Rate Code

The table below provides a summary of billing for Children and Family Treatment and Support Services (CFTSS). For a detailed guide on how to bill these services please reference the NYS Billing Manual.

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
OLP Licensed Evaluation	7900	90791	EP	15 Minutes	10
OLP Counseling -Individual	7901	H0004	EP	15 Minutes	4
OLP Counseling – Family (with or without the client present)	7901	H0004	HR – Family with client HS – Family without client	15 Minutes	4
OLP Crisis (Offsite, In-person only)	7902	H2011	EP, ET	15 Minutes	8
OLP Crisis Triage (By Phone)	7903	H2011	EP, GT	15 Minutes	2
OLP Crisis Complex Care (Follow up)	7904	90882	EP, TS	5 Minutes	4
OLP Counseling - Group	7905	H0004	HQ, EP	15 Minutes	4
Offsite – OLP Evaluation, Individual or Family (with or without the client present)	7920	90791 or H0004 depending on service provided	90791- EP, SC - Evaluation H0004 -SC - Individual H0004 – HR, SC – Family with client H0004 – HS, SC – Family without client	15 Minutes	10 for Evaluation 4 for Individual or Family Counseling

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Offsite – OLP Counseling Group	7927	H0004	EP, HQ, SC	15 Minutes	4
CPST Service Professional – Individual and/or Family (with or without the client)	7911	H0036	EP	15 Minutes	6
CPST Service Professional -Group	7912	H0036	EP, HQ	15 Minutes	4
Offsite- CPST Individual and/or Family (with or without the client)	7921	H0036	EP, SC	15 Minutes	6
Offsite – CPST Group	7928	H0036	EP, HQ, SC	15 Minutes	4
PSR Service Professional	7913	H2017	EP	15 Minutes	8
PSR Service Professional -Group	7914	H2017	EP, HQ	15 Minutes	4
Offsite- PSR Individual	7922	H2017	EP, SC	15 Minutes	8
Offsite – PSR Group	7929	H2017	EP, HQ, SC	15 Minutes	4
FPS Service Professional	7915	H0038	EP, UK	15 Minutes	8

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
FPS Service Professional - Group	7916	H0038	EP, UK, HQ	15 Minutes	6
Offsite- FPS/YPS - Individual	7923	H0038	EP, UK, SC	15 Minutes	8
Offsite – FPSS/YPST -Group	7930	H0038	EP, HQ, SC, UK	15 Minutes	6
YPS Service Professional	7917	H0038	EP	15 Minutes	8
YPS Service Professional -Group	7918	H0038	EP, HQ	15 Minutes	6
Offsite- FPS/YPS - Individual	7923	H0038	EP, SC	15 Minutes	8
Offsite – FPSS/YPST Group	7930	H0038	EP, HQ, SC	15 Minutes	6

Mobile Crisis					
One-person response: Licensed	7906	H2011	EP, HO	15 Minutes	6/day
Two-person Response: Licensed and Unlicensed/Certified Peer	7907	H2011	EP, HT	15 Minutes	6/day
Two-person Response: Both Licensed	7908	H2011	EP	15 Minutes	6/day
Two-person Response: Licensed and Unlicensed/Certified Peer	7909	S9484	EP	Per Diem	1/day

Mobile Crisis					
Two-person Response: Licensed and Unlicensed/Certified Peer	7910	S9485	EP	Per Diem	1/day
Two Person Response: Both Licensed (90-180 minutes)	7936	S9484	EP, HO	Per diem (90- 180 minutes)	1/day
Two Person Response: Both Licensed (over 3 hours)	7937	S9485	EP, HO	Per diem greater than 180 minutes	1/day
Mobile Follow up Services					
One Person Face-to- Face Follow-Up: Licensed	7938	H2011	TS, HO	15 minutes	6/day
One Person Face-to- Face Follow-Up: Unlicensed/Certified Peer	7939	H2011	TS, HM, HA	15 minutes	6/day
Two-person Face-to- Face Follow-Up: Licensed and Unlicensed	7940	H2011	TS, HT	15 minutes	6/day
Telephonic Follow up Services					
Telephonic Follow-Up: Licensed	7941	H2011	TS, HO, GT	15 minutes	4/day
CI Telephonic follow up Unlicensed/Certified Peer	7942	H2011	TS, HM, GT	15 minutes	4/day
Crisis Residential Services					
Residential Crisis Support	7943	H2013	HA, TF	per diem	1/day
Intensive Crisis Residence (ICR) 18-20 years	7944	H2013	HA, HK	per diem	1/day
Children's Crisis Residence	7945	H2013	HA	per diem	1/day

Program Type	Age Range	Rate Code	CPT Code	Modifier	Unit Measure	Length of Stay Limit
Children's Crisis Residence	Under 21	7945	H2013	HA	Per Diem	28 days per admission; unless otherwise approved by MMCP/OMH
Residential Crisis Support	18-20	7943	H2013	HA, TF	Per Diem	28 days per admission
Intensive Crisis Residence	18-20	7944	H2013	HA, HK	Per Diem	28 days per admission

Children HCBS Services Rate Code

The table below provides a summary of billing for Children HCBS Services. For a detailed guide on how to bill these services please reference the NYS Billing Manual.

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Caregiver Family Supports and Services - Individual	8003	H2014	UK, HA	15 minutes	12
Caregiver Family Supports and Services - Group of 2	8004	H2014	HA, UK, UN	15 minutes	12

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Caregiver Family Supports and Services - Group of 3	8005	H2014	HA, UK, UP	15 minutes	12
Prevocational Services -Individual	8006	T2015	HA	Per hour	2
Prevocational Services -Group of 2	8007	T2015	HA, UN	Per hour	2
Prevocational Services -Group of 3	8008	T2015	HA, UP	Per hour	2
Community Advocacy and Support -Individual	8009	H2015	HA	15 minutes	12
Community Advocacy and Support -Group of 2	8010	H2015	HA, UN	15 minutes	12
Community Advocacy and Support -Group of 3	8011	H2015	HA, UP	15 minutes	12
Supported Employment	8015	H2023	HA	15 minutes	12
Palliative Care Pain and Symptom Management	8016	99342	TJ	30 minutes	No limit, as required by participant's physician

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Palliative Care Pain and Symptom Management	8016	99347	TJ	15 minutes	No limit, as required by participant's physician
Palliative Care Bereavement Services	8017	90832	TJ	30 minutes	Limited to the lesser of 5 appointments per month or 60 hours per calendar year
Palliative Care Massage Therapy	8018	97124	TJ	15 minutes	12 appointment limits can be exceeded when medically necessary
Palliative Care Expressive Therapy	8019	96152	TJ	15 minutes	48 limit can be exceeded when medically necessary
Planned Respite - Individual (under 4 hours)	8023	S5150	HA	15 minutes	16
Planned Respite - Individual per diem (4+ hours)	8024	S5151	HA	Per Diem	1
Planned Respite - Group (under 4 hours)	8027	S5150	HA, HQ	15 minutes	16

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Crisis Respite - under 4 hours	8028	S5150	HA, ET	15 minutes	16
Crisis Respite - more than 4 hours, less than 12 hours	8029	S5151	HA, ET	Per Diem	1
Crisis Respite - Individual (12+ hours, less than 24 hours)	8030	S5151	HA, ET, HK	Per Diem	1
Day HCBS Habilitation	7933	T2020	HA	15 minutes	24
Day HCBS Habilitation - Group of 2	7934	T2020	HA, UN	15 minutes	24
Day HCBS Habilitation - Group of 3 or more	7935	T2020	HA, UP	15 minutes	24
Community HCBS Habilitation	8012	H2014	HA	15 minutes	24
Community HCBS Habilitation - Group of 2	8013	H2014	HA, UN	15 minutes	24

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Community HCBS Habilitation - Group of 3 or more	8014	H2014	HA, UP	15 minutes	24
Environmental Modifications	8032	S5165	HA	\$1.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Environmental Modifications	8034	S5165	HA, V1	\$10.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Environmental Modifications	8035	S5165	HA, V2	\$100.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Environmental Modifications	8036	S5165	HA, V3	\$1000.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Vehicle Modifications	8041	T2039	HA	\$1.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Vehicle Modifications	8042	T2039	HA, V1	\$10.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary
Vehicle Modifications	8043	T2039	HA, V2	\$100.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Vehicle Modifications	8044	T2039	HA, V3	\$1000.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Adaptive and Assistive Equipment	8037	T2028	HA	\$1.00	Cannot exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Adaptive and Assistive Equipment	8038	T2028	HA, V1	\$10.00	Cannot exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Adaptive and Assistive Equipment	8039	T2028	HA, V2	\$100.00	Cannot exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Adaptive and Assistive Equipment	8040	T2028	HA, V3	\$1000.00	Cannot exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.

10. UTILIZATION MANAGEMENT

Accessibility Standards

TYPE OF APPOINTMENT/ SERVICE	APPOINTMENT ACCESS TIMEFRAMES AND EXPECTATIONS
General Appointment Standards	
Routine/Non-Urgent	Within 1 week
Urgent Care	Within 24 hours
Emergency Services	Immediately; 24 hours a day, 7 days per week

Children CFTSS and HCBS Specific Standards

Crisis Respite	Within 24 hours of request
Planned Respite	Within 1 week of request
Psychosocial Rehabilitation,	Urgent -within 72 hours of request; non-urgent- within 5 business days of request; pursuant to an emergency or hospital discharge or release from incarceration- within 72 hours of request
Community Psychiatric Support and Treatment	Urgent-within 24 hours; non-urgent-within 1 week of request; pursuant to an emergency or hospital discharge or release from incarceration- within 72 hours of request
Habilitation Services	Within 2 weeks of request
Caregiver/Family Supports and Services	Within 5 business days of request
Educational and Employment Support Services	Within two weeks of request

TYPE OF APPOINTMENT/ SERVICE	APPOINTMENT ACCESS TIMEFRAMES AND EXPECTATIONS
Peer Support Services	Within one week of request (unless appointment is pursuant to emergency or hospital discharge, in which case the standard is five days; or if services are needed urgently for symptom management, in which case the standard is 24 hours)

Aftercare Appointment Standards (*Inpatient and 24-hour diversionary services must schedule an aftercare follow-up prior to a member's discharge*)

Non-24-hour Diversionary	Within two calendar days
Psychopharmacology Services/ Medication Management	Within 14 calendar days

SERVICE AVAILABILITY	HOURS OF OPERATION
On-Call	<ul style="list-style-type: none"> ▪ 24-hour on-call services for all members in treatment ▪ Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations
Crisis Intervention	<ul style="list-style-type: none"> ▪ Services must be available 24 hours per day, 7 days per week ▪ Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours ▪ After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency affiliated staff, crisis team, or hospital emergency room. For PCPs and OB/GYN providers, this includes providing access to a live voice for afterhours emergency consultation and care. If the provider uses an answering machine, the message must direct the member to a live voice. ▪ Providers are responsible for the crisis management of members in their care. Should a member in behavioral health crisis call Carelon (via the toll-free main number), the member will be connected with a clinician to address the crisis and ensure connection to crisis services. Following the intervention, Carelon will outreach to the provider to follow-up with the member and refer the member to care.

Outpatient Services	<ul style="list-style-type: none"> ▪ Outpatient providers should have services available Monday through Friday, from 8 a.m. to 5 p.m., ET at a minimum ▪ Evening and/or weekend hours should also be available at least two days per week
Interpreter Services	<ul style="list-style-type: none"> ▪ Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency

For a table of Foster Care Initial Health Services, see Table 3 in Attachment 1.

Providers are required to meet these standards, and to notify Carelon if they are temporarily or permanently unable to meet the standards. If a provider fails to begin services within these access standards, notice is sent out within one business day informing the member and provider that the waiting time access standard was not met.

New York Ambulatory Behavioral Health Services Authorization Rules

The NYS OMH and OASAS has issued guidance on authorization rules for ambulatory behavioral health services for adults. Below are the authorization guidance and expectations for timely appointments for behavioral health services within Mainstream Managed Care, HIV Medicaid SNP, and Health and Recovery Plans cover. Following an emergency, hospital discharge or release from incarceration, if known, follow up visits with a behavioral health participating provider should be offered within a minimum of five days of request or as clinically indicated.

Members may also self-refer for at least OB/GYN care: prenatal care, two routine visits per year and any follow-up care, acute gynecological condition. For Medicaid/FHP, they may also self-refer for:

- At least one mental health visit and one substance abuse visit with a participating provider per year for evaluation. (Note: Carelon allows members to self-refer to all outpatient behavioral health services)
- Vision services with a participating provider
- Diagnosis and treatment of TB by public health agency facilities
- Family planning and reproductive health from participating provider or Medicaid provider

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
Outpatient mental health office and clinic services including: initial assessment; psychiatric assessment; psychosocial assessment; medication treatment; and individual, family/collateral, and group psychotherapy	No	Yes	MMCOs/HARPs must pay for at least 30 visits per treatment episode without requiring authorization. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law. Non-urgent appointments should be offered within two to four weeks of request.
Psychological or neuropsychological testing	Yes	N/A	Non-urgent appointments should be offered within two to four weeks of request.

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	<p>Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill</p> <p>the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit. Appointment should be given within 24 hours of request.</p>
Personalized Recovery Oriented Services (PROS) Admission: Individualized Recovery Planning	Yes	Yes	<p>Begins when IRP is approved by Plan. Concurrent review and authorizations should occur at three-month intervals for IR and ORS services and at six-month intervals for Base/Community Rehabilitation and Support (CRS) and Clinic Treatment services. Appointments should be offered within two weeks of request.</p>
Mental Health Continuing Day Treatment (CDT)	Yes	Yes	<p>Appointment should be offered within two to four weeks of request</p>
Mental Health Intensive Outpatient (note: NOT State Plan)	Yes	Yes	<p>Appointment should be offered within one week of request</p>

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
Mental Health Partial Hospitalization	Yes	Yes	
Assertive Community Treatment (ACT)	No	Yes	New ACT referrals must be made within 24 hours and should be made through local Single Point of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT.
Outpatient Office and Clinic Services provided by OASAS-certified agencies including: initial assessment; psychiatric assessment; psychosocial assessment; medication treatment; and individual, family/collateral, and group psychotherapy	No	Yes	<p>LOCADTR tool to inform level of care determinations.</p> <p>Appointments should be offered within 24 hours of request.</p>
Medically Supervised Outpatient Substance Withdrawal	No	No	<p>LOCADTR tool to inform level of care determinations.</p> <p>Appointments should be offered within 24 hours of request.</p>

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
Opioid Treatment Program (OTP) Services	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.
Substance Use Disorder Intensive Outpatient	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within one week of request.
Substance Use Disorder Day Rehabilitation	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within two to four weeks of request.
Stabilization and Rehabilitation services for residential SUD treatment	Yes	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.

If a service is not a covered benefit, providers are expected to advise the member prior to initiating the services to state the cost of the service.

See Carelon national handbook for additional information

11. QUALITY MANAGEMENT/QUALITY IMPROVEMENT

Ambulatory Mental Health Services for Children

Table 1. Authorization Requirements for Benefits and Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care population

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
Assertive Community Treatment	No	No	FFS
Youth Assertive Community Treatment (ages 10 – 21 years old)	No	No	N/A
CFCO State Plan Services for Children Meeting Eligibility Criteria ¹	Will be managed by the health plan	Will be managed by the health plan	N/A
Children's Crisis Intervention (Former 1915(c) waiver service, transitioning to State Plan EPSDT Benefit)	No	No	FFS
Children's Day Treatment	Yes	Yes	FFS
Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed	No	No	FFS (Current MMC Benefit for individuals age 21 and over)
Continuing Day Treatment (minimum age is 18 for medical necessity for this adult-oriented service)	Yes	Yes	FFS

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
Community Psychiatric Support and Treatment (CPST ²)	No	No	N/A (New State Plan service)
Crisis Intervention Demonstration Service	No	No	MMC Demonstration Benefit for all ages
Family Peer Support Services	No	No	FFS/1915(c) Children's waiver service
Health Home Care Management	No	No	FFS
Inpatient Psychiatric Services	Yes	Yes	Current MMC Benefit
Licensed Behavioral Health Practitioner (NP-LBHP) Service	No	No	MMC Demonstration Benefit for all ages
OMH and OASAS Licensed Outpatient Clinic Services	No	No	Current MMC Benefit

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
Medically Managed Detoxification (hospital-based)	Per NY legislation, if services are provided in NY and in-network, notification is required within 48 hours of admission for a 28-day registration. Authorization is required if out-of-state/out-of-network admission or lack of notification within 48 hours of admission.	Yes, after a 28 day registration period.	Current MMC Benefit
Medically Supervised Inpatient Detoxification	Per NY legislation, if services are provided in NY and in-network, notification is required within 48 hours of admission for a 28-day registration. Authorization is required if out-of-state/out-of-network admission or lack of notification within 48 hours of admission.	Yes, after a 28 day registration period.	Current MMC Benefit
Medically Supervised Outpatient Withdrawal	No	No	Current MMC Benefit

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
OASAS Inpatient Rehabilitation Services	Per NY legislation, if services are provided in NY and in-network, notification is required within 48 hours of admission for a 28-day registration. Authorization is required if out-of-state/out-of-network admission or lack of notification within 48 hours of admission.	Yes, after a 28 day registration period.	Current MMC Benefit
OASAS Opioid Treatment Program (OTP) Services	No	No	FFS ³
OASAS Outpatient and Residential Addiction Services	No	No	MMC Demonstration Benefit for all ages
OASAS Outpatient Rehabilitation Programs	No	No	FFS ⁴
OASAS Outpatient Services	No	No	FFS ⁵
OMH State Operated Inpatient	Yes	Yes	FFS
Other Licensed Practitioner (OLP)	No	No	N/A (New State Plan Service)
Partial Hospitalization	Yes	Yes	FFS

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
Personalized Recovery Oriented Services (PROS) (minimum age is 18 for medical necessity for this adult-oriented service)	No	No	FFS
Psychosocial Rehabilitation (PSR)	No	No	N/A (New State Plan Service)
Rehabilitation Services for Residents of Community Residences	Yes	Yes	FFS
Residential Rehabilitation Services for Youth (RRSY)	Yes	Yes	FFS
Residential Supports and Services (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)	No	No	OCFS Foster Care
Residential Treatment Facility (RTF)	Yes	Yes	FFS
Teaching Family Home	N/A	N/A	FFS

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
Youth Peer Support and Training	No	No	FFS/1915(c) Children's waiver service

³For OASAS hospital-based programs.

⁴For OASAS hospital-based programs.

⁵For OASAS hospital-based programs.

Table 2. Appointment Availability Standard by Service Type

SERVICE TYPE	EMERGENCY	URGENT	NON-URGENT	FOLLOW-UP TO EMERGENCY OR HOSPITAL DISCHARGE	FOLLOW-UP TO RESIDENTIAL SERVICES, DETENTION DISCHARGE, OR DISCHARGE FROM JUSTICE SYSTEM PLACEMENT
MH Outpatient Clinic		Within 24 hours	Within 1 week	Within 5 business days of request	Within 5 business days of request
Partial Hospitalization				Within 5 business days of request	
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				
OASAS Outpatient Clinic		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request

SERVICE TYPE	EMERGENCY	URGENT	NON-URGENT	FOLLOW-UP TO EMERGENCY OR HOSPITAL DISCHARGE	FOLLOW-UP TO RESIDENTIAL SERVICES, DETENTION DISCHARGE, OR DISCHARGE FROM JUSTICE SYSTEM PLACEMENT
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hours			
OTP		Within 24 hours			
Crisis Intervention	Within 1 hour			Within 24 hours of Mobile Crisis Intervention response	
CPST		Within 24 hours (for intensive in home and crisis response services under definition)	Within 1 week of request	Within 72 hours of discharge	Within 72 hours
OLP		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Family Peer Support Services		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Youth Peer Support and Training			Within 1 week of request	Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within 5 business days of request	Within 72 hours of request	Within 72 hours of request

SERVICE TYPE	EMERGENCY	URGENT	NON-URGENT	FOLLOW-UP TO EMERGENCY OR HOSPITAL DISCHARGE	FOLLOW-UP TO RESIDENTIAL SERVICES, DETENTION DISCHARGE, OR DISCHARGE FROM JUSTICE SYSTEM PLACEMENT
Caregiver/Family Supports and Services			Within 5 business days of request	Within 5 business days of request	Within 5 business days of request
Crisis Respite	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	
Planned Respite			Within 1 week of request	Within 1 week of request	
Prevocational Services			Within 2 weeks of request		Within 2 weeks of request
Supported Employment			Within 2 weeks of request		Within 2 weeks of request
Community Self-Advocacy Training and Support			Within 5 business days of request		Within 5 business days of request
Habilitation			Within 2 weeks of request		
Adaptive and Assistive Equipment		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within 2 weeks of request	Within 24 hours of request	

Table 3. Foster Care Initial Health Services Time Frames

TIME FRAME	ACTIVITY	MANDATED ACTIVITY	MANDATED TIME FRAME	WHO PERFORMS
24 Hours	Initial screening/ screening for abuse/ neglect	X	X	Health practitioner (preferred) or Child Welfare caseworker/ health staff
5 Days	Initial determination of capacity to consent for HIV risk assessment & testing	X	X	Child Welfare Caseworker or designated staff
5 Days	Initial HIV risk assessment for child without capacity to consent	X	X	Child Welfare Caseworker or designated staff
10 Days	Request consent for release of medical records & treatment	X	X	Child Welfare Caseworker or health staff
30 Days	Initial medical assessment	X	X	Health practitioner
30 Days	Initial dental assessment	X	X	Health practitioner
30 Days	Initial mental health assessment	X		Mental health practitioner
30 Days	Family Planning Education and Counseling and follow-up health care for youth age 12 and older (or younger as appropriate)	X	X	Health practitioner
30 Days	HIV risk assessment for child with possible capacity to consent	X	X	Child Welfare Caseworker or designated staff

TIME FRAME	ACTIVITY	MANDATED ACTIVITY	MANDATED TIME FRAME	WHO PERFORMS
30 Days	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	X	X	Child Welfare Caseworker or health staff
45 Days	Initial developmental assessment	X		Health practitioner
45 Days	Initial substance abuse assessment			Health practitioner
60 Days	Follow-up health evaluation			Health practitioner
60 Days	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent & assessed to be at risk of HIV infection	X	X	Child Welfare Caseworker or health staff
60 Days	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	X	X	Child Welfare Caseworker or health staff

See Carelon national handbook for more information