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CARELON BEHAVIORAL HEALTH

NEW YORK HEALTH AND RECOVERY PLAN (HARP) PROGRAM

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 the New York Health and Recovery Plan (HARP) Program.*

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New York Health and Recovery Plan (HARP) Program

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 the New York Health and Recovery Plan (HARP) Program.

1. INTRODUCTION

About the HARP Program

A Health and Recovery Plan (HARP) is a special needs plan that focuses on adults with significant behavioral health needs. The plan addresses these needs through the integration of physical health, mental health, and substance use services. In addition to the State Plan Medicaid services offered by mainstream MCOs, the HARP offers access to an enhanced benefit package comprised of 1915(i)-like Home and Community Based services designed to provide the individual with a specialized scope of support services.

Section 1915i of the Social Security Act was established as part of the Deficit Reduction Act of 2005. 1915i afforded States the opportunity to provide HCBS under the Medicaid State Plan without the requirement that Medicaid members need to meet the institutional level of care as they do in a 1915(c) HCBS Waiver. The intent is to allow and encourage states to use the flexibility of HCBS services to develop a range of community-based supports, rehabilitation and treatment services with effective oversight to assure quality. These services are designed to allow individuals to gain the motivation, functional skills and personal improvement to be fully integrated into communities. The 1915i option acknowledges that even though people with disabilities may not require an institutional level of care (e.g. hospital, nursing home) they may still be isolated and not fully integrated into society. This isolation and lack of integration may have been perpetuated by approaches to service delivery which cluster people with disabilities, and don't allow for flexible, individualized services or services which promote skill development and community supports to overcome the effects of certain disabilities or functional deficits, motivation and empowerment.

HARP Model of Care

The HARP model of care is a recovery model. This model emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance disorders through empowerment, choice, treatment, educational, vocational, housing, and health and well-being goals. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, self- direction, social inclusion, and coping skills.

At a 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation convened by SAMHSA, patients, health-care professionals, researchers and others agreed on 10 core principles undergirding a recovery orientation. Providers working with HARP eligible members, and especially those providing HCBS Services, must implement processes to ensure clinical work adheres to recovery-based principles including but not limited to:

- Self-direction: Consumers determine their own path to recovery.
- Individualized and person-centered: There are multiple pathways to recovery based on individuals' unique strengths, needs, preferences, experiences and cultural backgrounds.
- Empowerment: Consumers can choose among options and participate in all decisions that affect them.
- Holistic: Recovery focuses on people's entire lives, including mind, body, spirit and community.
- Nonlinear: Recovery isn't a step-by-step process but one based on continual growth, occasional setbacks and learning from experience.
- Strengths-based: Recovery builds on people's strengths.
- Peer support: Mutual support plays an invaluable role in recovery.
- Respect: Acceptance and appreciation by society, communities, systems of care and consumers themselves are crucial to recovery.
- Responsibility: Consumers are responsible for their own self-care and journeys of recovery.
- Hope: Recovery's central, motivating message is a better future — that people can and do overcome obstacles.

Carelon will evaluate the use of Recovery Principles in care during both utilization management activities,quality evaluations and chart review processes.

HARP Enrollment and Eligibility Process

Unlike other Medicaid Redesign initiatives, enrollment in a HARP plan is not "mandatory". This initiative offers potentially eligible individuals the chance to enroll in a qualified plan that offers enhanced benefits. Individuals are then screened for eligibility and a personalized recovery plan is developed that specifies the scope, type and duration of services the member is eligible to receive. Individuals will initially be identified by New York State as potentially needing HARP services on the basis of historical service use. Once a member is identified as HARP eligible, they can enroll in a HARP at any point.

A key goal in this managed care design is to avoid disrupting access to physical health care for individuals already enrolled in a mainstream Plan. Therefore, individuals initially identified as HARP eligible who are already enrolled in an MCO with a HARP will be passively enrolled in that Plan's HARP. This will ensure that Plan members will continue to have access to the same network of physical health services as the new BH benefits are brought into the Plan. As part of the passive enrollment process, these individuals will be informed about HARP benefits as well as their ability to stay in their existing mainstream Plan, choose another HARP or opt out of the HARP plan. Individuals will have 30 days to opt out or switch to a new HARP plan. Once enrolled in a HARP, members will be given 90 days to choose another HARP or return to Mainstream before they are locked into the HARP for nine additional months (after which they are free to change Plans at any time). HARP eligible individuals in an HIV SNP will be able to receive HCBS services through the HIV SNP. They will also be given the opportunity to enroll in another HARP. They will be notified of their HARP eligibility and referred to the NYS Enrollment Broker to help them decide which Plan is right for them. Individuals initially identified as HARP eligible who are already enrolled in an MCO without a HARP will be notified by their Plan of their HARP eligibility and referred to an enrollment broker to help them decide which Plan is right for them. Individuals enrolled in an MCO without a HARP are not required to dis-enroll from their current plan to join a HARP plan but plan without a HARP are not required to offer 1915 (i) like services.

For full details on QMP and HARP, including OMH and OASAS specific guidance, please go to www.omh.ny.gov/omhweb/bho/ or the OMH Guidance memo in Attachment 1 at the end of this document.

Eligibility and Assessment – HARP and Home and Community-Based Services

Medicaid members are identified by New York State as a member with a serious condition who may benefit from additional coordination of care and Medicaid Waiver Services (HCBS). Health Plans are notified by NYS of a member's eligibility for HARP and eligibility for a Community Assessment. It must be in compliance with conflict free case management requirements and will determine the level of need, or eligibility, to have additional services (HCBS) available to them. The assigned Health Homes must develop a Plan of Care indicating the need, as defined by the assessment, of the HCBS services.

All HARP eligible members and/or those members identified as in need of additional support, will receive Plan based case management. Specific triggers that may result in a referral for case management include: Carelon case management can aid in the assessment, identification of providers, timely access to services and the development of their person-centered Plan of Care. Additionally, consenting HARP members will be connected to Health Home Care Coordination.

Behavioral Health Services

Carelon defines "behavioral health" as both acute and chronic psychiatric and substance use disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Disorders DSM and/or ICD of the American Psychiatric Association.

Accessible Intervention and Treatment

Carelon promotes health screening for identification of behavioral health problems and patient education. Providers are expected to:

- Screen, evaluate, treat and/or refer (as medically appropriate), any behavioral health problem. Primary care providers may treat for mental health and/or substance use disorders within the scope of their practice and bill using DSM and/or ICD codes.
- Inform members how and where to obtain behavioral health services
- Understand that members may self-refer to any behavioral health care provider without a referral from the member's primary care provider

This can be achieved by providing members with access to a full continuum of mental health and substance use disorder services through Carelon’s network of contracted providers.

First Episode Psychosis

Providers will assess for and promptly refer members experiencing first episode psychosis to specialty programs or program utilizing evidence based practices for this condition, such as:

OnTrackNY Providers, trained by The Center for Practice Innovations (CPI) at Columbia Psychiatry/NYS Psychiatric Institute, deliver coordinated, specialty care, for those experiencing FEP, including: "psychiatric treatment, including medication; cognitive-behavioral approaches, including skills training; individual placement and support approach to employment and educational services; integrated treatment for mental health and substance use problems; and family education and support" (CPI website). Each site has the ability to care for up to 35 individuals. Requirements:

- Ages 16-30
- Began experiencing psychotic symptoms for more than a week, but, less than two years, prior to referral
- Borderline IQ or above, such that individual is able to benefit from services offered. Providers who need to refer members for further behavioral health care should contact Carelon.

HARP Covered Benefits and Services

Behavioral Health Benefits for all Medicaid Populations

- Assertive Community Treatment (ACT)
- Comprehensive psychiatric emergency program
- Continuing day treatment
- Gambling Disorder Treatment
- Home Care Coordination and Management
- Inpatient hospital detoxification (OASAS service)
- Inpatient medically supervised inpatient detoxification (OASAS Service)
- Inpatient psychiatric services (OMH service)
- Inpatient treatment (OASAS service)
- Intensive case management/ supportive case management
- Medically supervised outpatient withdrawal (OASAS services)
- Mobile Crisis and Crisis Residence services
- Outpatient clinic and opioid treatment program (OTP) services (OASAS services)
- Outpatient clinic services (OMH services)
- Partial hospitalization
- Personalized Recovery Oriented Services (PROS)
- Rehabilitation services for residential SUD treatment supports (OASAS service)
- Rehabilitation services for residents of community residences

Additional Core Services for Adults

- Community Psychiatric Support and Treatment (CPST)
- Empowerment Services – Peer Support (Peer Support)
- Family Support and Training (FST)
- Psychosocial Rehabilitation (PSR)

Additional HCBS Services for Adults Meeting Targeting and Functional Needs

- Habilitation
- Non-medical transportation
- Employment Services
    - Pre-vocational
    - Transitional Employment Support Intensive Employment Support
    - Ongoing Supported Employment
- Education Support Services

For additional information on HCBS services please refer to the HCBS Manual, available on the OMH website https://omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf. Effective January 1, 2023, Gambling Disorder Treatment will be added to the MMC benefit package when provided through Office of Addiction Services and Supports (OASAS) certified programs. MMC Plans will begin covering Gambling Disorder Treatment provided to individuals receiving services from the following OASAS certified programs.

Outpatient:

- OASAS Certified Title 14 NYCRR Part 822 Outpatient Clinic with a Problem Gambling designation.

- OASAS Certified title 14 NYCRR Part 825 integrated outpatient services with the OASAS gambling designation.

Inpatient:

- OASAS Certified Title 14 NYCRR Part 818 Inpatient Rehabilitation Programs Residential
- OASAS Certified Title 14 NYCRR Part 820 Residential Treatment Programs

New York State Medicaid Advantage Plus (MAP) Plans

Effective January 1, 2023, New York State (NYS) begun carving additional Behavioral Health (BH) services into the Medicaid Advantage Plus (MAP) Plan benefit package. MAP Plans are a type of Dual Eligible-Special Needs Plan (D-SNP) combined with a Medicaid Managed Long-Term Care (MLTC) Plan, which administer Medicare and Medicaid benefits, including Medicaid long-term care services. Utilization management and eligibility requirements for mental health and addiction services included in the MAP benefit package will be the same as the requirements in Medicaid Health and Recovery Plans (HARPs) and the Mainstream Managed Care benefits.

2. ELECTRONIC RESOURCES

See Carelon national handbook

3. PARTICIPATING PROVIDERS

Contracting and Maintaining Network Participation

A "Participating Provider" is an individual practitioner, private group practice, licensed outpatient agency, New York State designated HCBS provider or facility that has been credentialed by and has signed a Provider Service Agreement (PSA) with Carelon. Participating providers agree to provide mental health and/or substance use services and/ or Home and Community Based Services to members; **have a procedure for monitoring HCBS utilization for each enrollee**; accept reimbursement directly from Carelon according to the rates set forth in the fee schedule attached to each provider's PSA; and adhere to all other terms in the PSA, including this provider manual. Note that New York State law currently requires that effective 10/1/15 in New York City and 7/1/15 in the rest of New York State, Plans must pay 100 percent of the Medicaid fee-for-service (FFS) rate (aka, "government rates") for all authorized behavioral health procedures delivered to individuals enrolled in mainstream Medicaid managed care plans, HARPs, and HIV SNPs when the service is provided by an OASAS and OMH licensed, certified, or designated program. This requirement remains in place for at least two full years. While alternative payment arrangements, in lieu of the FFS rates, may be allowed they require prior approval from OMH and OASAS.

4. CREDENTIALING AND RE-CREDENTIALING

Home and Community Based Provider Designation

In order to provide HCBS to Carelon HARP eligible individuals, a program must be designated by New York State 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

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 collects 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.

See Carelon national handbook for more information

5. OFFICE PROCEDURES

See Carelon national handbook

6. SERVICES TO MEMBERS

See Carelon national handbook

7. MEMBER RIGHTS AND RESPONSIBILITIES

See Carelon national handbook

8. PARTICIPATING PROVIDER COMPLAINTS AND GRIEVANCES

See Carelon national handbook

9. CLAIMS PROCEDURES

Billing of Expanded Services

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

Beginning January 1, 2025, NYS is implementing 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 grid below for your 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	None	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 free-standing, 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 SUD 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 (OTP)

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 Opioid Treatment Programs 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 FFS 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 DependenceOutpatient Clinic Program	1540
Part 822 Community (Art 32 only) Chemical DependenceOutpatient Rehab Program	1573
Part 822 Community (Art 32 only) Opiate Treatment Program	1564
Medical Services	
Part 822 Community (Art 32 only) Chemical DependenceOutpatient Program	1468
Part 822 Community (Art 32 only) Chemical DependenceOutpatient 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 f r o m 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.

RATECODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OF SERVICE
4310	CDT Half Day 1-40	H2012	Behavioral Health Day Treatment, perhour	U1, U5	2-3
4311	CDT Half Day41-64	H2012	Behavioral Health Day Treatment, perhour	U2, U5	2-3
4312	CDT Half Day 65+	H2012	Behavioral Health Day Treatment, perhour	U3, U5	2-3
4316	CDT Full Day 1-40	H2012	Behavioral Health Day Treatment, perhour	U1	4-5
4317	CDT Full Day41-64	H2012	Behavioral Health Day Treatment, perhour	U2	4-5

RATECODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OF SERVICE
4318	CDT Full Day 65+	H2012	Behavioral Health Day Treatment, perhour	U3	4-5
4325	CDT Collateral	H2012	Behavioral Health Day Treatment, perhour	UK	1
4331	CDT Group Collateral	H2012	Behavioral Health Day Treatment, perhour	UK, HQ	1
4337	CDT Crisis	H2012	Behavioral Health Day Treatment, perhour	U8	1
4346	CDT Pre-Admission	H2012	Behavioral Health Day Treatment, perhour	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 dailybasis
4008	Full Evaluation	90791	Psych Evaluation	HK	1	Billed on a dailybasis
4049	Extended Observation					See Notes above

INTENSIVE PSYCHIATRIC REHABILITATION TREATMENT (IPRT)

An IPRT claim is submitted on a daily basis. The applicable rate code/procedure code/modifier codes combination is dependent on the number of hours of service in the day. The combinations are listed on the crosswalk below. Reimbursement is provided for service duration of at least one hour and not more than five hours per recipient, per day.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OF SERVICE
4364	IPRT 1 Hour	H2012	Behavioral Health Day Treatment, per hour	HK, U1	1
4365	IPRT 2 Hours	H2012	Behavioral Health Day Treatment, per hour	HK, U2	2
4366	IPRT 3 Hours	H2012	Behavioral Health Day Treatment, per hour	HK, U3	3
4367	IPRT 4 Hours	H2012	Behavioral Health Day Treatment, per hour	HK, U4	4
4368	IPRT 5 Hours	H2012	Behavioral Health Day Treatment, per hour	HK, U5	5

PARTIAL HOSPITALIZATION

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4349	Partial Hospitalization Regular - 4 hours	H0035	MH partial hosp tx under 24h	U4, [UA]	4	Billed daily. Code with 4 units. This code does not pay in APGs. Add the UA modifier if the service is a pre-admission.
4350	Partial Hospitalization Regular - 5 hours	H0035	MH partial hosp tx under 24h	U5, [UA]	5	Billed daily. Code with 5 units. This code does not pay in APGs. Add the UA modifier if the service is a pre-admission.
4351	Partial Hospitalization Regular - 6 hours	H0035	MH partial hosp tx under 24h	U6, [UA]	6	Billed daily. Code with 6 units. This code does not pay in APGs. Add the UA modifier if the service is a pre-admission.
4352	Partial Hospitalization Regular - 7 hours	H0035	MH partial hosp tx under 24h	U7, [UA]	7	Billed daily. Code with 7 units. This code does not pay in APGs. Add the UA modifier if the service is a pre-admission.
4353	Partial Hospital Collateral - 1 hour	H0035	MH partial hosp tx under 24h	U1, HR or HS	1	Billed daily. Code with 1 unit. Use HR or HS modifier (in addition to U1). This code does not pay in APGs.
4354	Partial Hospital Collateral - 2 hours	H0035	MH partial hosp tx under 24h	U2, HR or HS	2	Billed daily. Code with 2 units. Use HR or HS modifier (in addition to U2). This code does not pay in APGs.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4355	Partial Hospital Group Collateral - 1 hour	H0035	MH partial hosp tx under 24h	U1, HQ, HR or HS	1	Billed daily. Code with 1 unit. Use HQ (group) modifier. Also use HR or HS modifier (in addition to HQ and U1). This code does not pay in APGs.
4356	Partial Hospital Group Collateral - 2 hours	H0035	MH partial hosp tx under 24h	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 Hospitalization 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 Hospitalization 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 Hospitalization 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 from clinic (APGs). 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)

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: IR, 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.

RATECODE	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 "PROSUnit Conversion Chart" on a dailybasis 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 affectpayment, as payment is the same throughoutthe range.
4516	PROS Comm Rehab Srvcs 2-12 Units	H2019	Ther behav svc, 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. The calculation of units is pending changes. Reflect the total PROS units for the month in the unit field of the claim. The number of units coded does not affect payment, as payment is the same throughout the range.
4517	PROS Comm Rehab Srvcs 13-27 Units	H2019	Ther behav svc, 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. The calculation of units is pending changes. Reflect the total PROS units for the month in the unit field of the claim. The number of units coded does not affect payment, as payment is the same throughout the range.

RATECODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4518	PROS Comm Rehab Srvcs 28-43 Units	H2019	Ther behav svc, per 15 min	U3	28-43	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. The calculation of units is pending changes. Reflect the total PROS units for the month in the unit field of the claim. The number of units coded does not affect payment, as payment is the same throughout the range.
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 PROSmonthly base rate services code or other PROS rate codes. This codepays in APGs. Use HE modifierto differentiate claim from clinic(APGs).
4526	PROS Int. Rehab	H2018	PsySoc Rehab Service, per diem	HE	1	This is a monthlyadd-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.

RATECODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4527	PROS Ongoing Rehab & Support	H2025	Supp maint employ, 15 min	HE	1	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. The calculation of units is pending changes. Reflect the total PROS units for the month in the unit field of the claim. The number of units coded does not affect payment, as payment is the same throughout the range.

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 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.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDUR ECODE 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 anOASAS Certified Residential Stabilization Program. The perdiem 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 anOASAS Certified Residential Rehabilitation Program. The perdiem excludes room and board.
1146	Reintegration per diem	H2036	Alcohol and/or Drug Halfway House Services, per diem	HF	1 / day	Daily Per Diem associated with treatment services delivered to patients within anOASAS Certified Re-Integration Program. The perdiem excludes room and board.

HARP HOME AND COMMUNITY BASED SERVICES (HCBS)

HCBS services are only available to HARP enrollees qualified through the assessment process and HARP 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). A HARP may also make these service available to an otherwise unqualified individual on an in lieu of basis. In order to be reimbursable, services rendered, including scope and duration must be part of an approved personalized recovery plan.

Patient specific annual limitations exist for HCBS services. These recipient level service thresholds are applied to each 12-month calendar year beginning on January 1st for every BH HCBS eligible member. HARPs and HIV-SNPs must adhere to the following Adult BH HCBS Utilization Thresholds:

1. Combined Tier 1 Adult BH HCBS (Employment Supports and Education Supports) will be limited to $8,000 as a group. NYS has defined a 25 percent corridor on this threshold that will allow HARPs and HIV SNPs to reimburse up to $10,000 per calendar year without a disallowance.

2. Combined Tier 1 AND Tier 2 Adult BH HCBS will have an overall annual cap of $16,000 per eligible member. A 25 percent corridor will also be applied to this threshold to enable HARPs and HIV-SNPs to reimburse up to $20,000 per calendar year without a disallowance.

When submitting claims for approved waiver program services:

- Claims should be submitted on a UB04 form or 837I file.

- Provider 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.

The table below provides a summary of billing for HCBS services.

RATE CODE	RATE CODE DESC.	PROC CODE	PROC.CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
7778	HCBS Eligibility Brief Assessment (by Health Home or arm's length entity under contract with HARP) (see note 1)	H0002	Behavioral health screening to determine eligibility for admission to treatment program	HH	None, code 1 unit	1	Maximum of three per year. Not to be billed on same day asfull assess.	On-site or off-site. This code also pays in APGs so use HH modifier to differentiate the claim. This service is paid by theHealth Plan, not Carelon.	Yes
7780	Plan of Care Development – Initial	T2024	Mental Health assessment, by non-physician		None, code 1 unit	1	Maximum of one per year.	On-site or off-site. This code also pays in APGs so use HH modifier to differentiat ethe claim. This service is paid by the Health Plan, not Carelon.	Yes
7781	Plan of Care Development – Ongoing	T2024	Service assessment/Plan of Care Development	U1			Maximum of 8 units per day and 48 units per year	Only for patients that refuse Health Home or awaiting slot. Use U1 modifier for ongoing POC activities.	

RATE CODE	RATE CODE DESC.	PROC CODE	PROC.CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
7784	Psychosocial Rehabilitation - Per 15 Minutes (individual - on-site)	H2017	Psychosocial rehabilitationservices; per15 minutes	U1	Per 15 min	8	Cannot be billed on thesame day as group or perdiem PSR.	On-site rate code.Use U1 modifier.	No
7785	Psychosocial Rehabilitation - Per 15 Minutes (individual - "one on one", off-site)	H2017	Psychosocial rehabilitationservices; per15 minutes	U2	Per 15 min	8	Cannot be billed on thesame day as group or perdiem PSR.	Off-site rate code.Use U2 modifier.	Yes
7786	Psychosocial Rehabilitation - Per 15 Minutes (group of 2 or 3)	H2017	Psychosocial rehabilitationservices; per15 minutes	UN or UP	Per 15 min	4	Cannot be billed on the same day asper diem PSR service.Not billable with mileage based transportatio n	Mostly on-site. Use appropriatemodifier.	No
7787	Psychosocial Rehabilitation - Per 15 Minutes (group of 4 or 5)	H2017	Psychosocial rehabilitationservices; per15 minutes	UQ or UR	Per 15 min	4	Cannot be billed on the same day asper diem PSR service.	Mostly on-site. Use appropriatemodifier.	No
7788	Psychosocial Rehabilitation - Per 15 Minutes (group of 6 or more)	H2017	Psychosocial rehabilitationservices; per15 minutes	US	Per 15 min	4	Cannot be billed on the same day asper diem PSR service.	Mostly on-site.	No

RATE CODE	RATE CODE DESC.	PROC CODE	PROC.CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
7789	Psychosocial Rehabilitation - Per Diem (individual only - "one on one")	H2018	Psychosocial Rehabilitation ; per diem		Per diem	1	Cannot be billed on thesame day as group or per15 minute PSR.	On-site or off-site. Minimum of 3hours.	Yes
7790	Community Psychiatric Support and Treatment (physician)	H0036	Community Psychiatric Supportive Treatment, face-to-face; per 15 min	AF	Per 15 min	6		Off-site only.No groups.	Yes
7791	Community Psychiatric Support and Treatment (NP, psychologist)	H0036	Community Psychiatric Supportive Treatment, face-to-face; per 15 min	SA or AH	Per 15 min	6		Off-site only.No groups.	Yes
7792	Community Psychiatric Support and Treatment (RN, LMHC, LMFT, LCSW, LMSW)	H0036	Community Psychiatric Supportive Treatment, face-to-face;per 15 min	TD or AJ	Per 15 min	6		Off-site only.No groups.	Yes
7793	Community Psychiatric Support and Treatment (all other allowable professions)	H0036	Community Psychiatric Supportive Treatment, face-to-face;per 15 min		Per 15 min	6		Off-site only. . No groups.	Yes

RATE CODE	RATE CODE DESC.	PROC CODE	PROC.CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
7794	Peer Supports - provided by credentialed staff	H0038	Self Help / Peer Services, per 15 minutes	HE or HF	Per 15 min	16		On-site or off-site. Use HE modifier for an "OMH service" or the HF modifier for an "OASAS service".	Yes
7795	Habilitation / Residential Supports Services	T2017	Habilitation, residential -waiver, 15 minutes		Per 15 min	12		On-site or off-site.	Yes
7796	Short-term Crisis Respite (in a dedicated facility)	H0045	Respite Care Services, not in the home; per diem	HK, U5	Per diem	1	Cannot be billed on same day asintensive crisis respite.	Limit - 7 daysper stay, 21 days per year. Must have PA before stay exceeds 72 hours. Billed daily. Bill U5 - reduced services modifier and HK modifier.	No

RATE CODE	RATE CODE DESC.	PROC CODE	PROC.CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
7797	Short-term Crisis Respite (in a non-dedicated facility, e.g., CR)	H0045	Respite Care Services, not in the home; per diem	HE, U5	Per diem	1	Cannot be billed on same day asintensive crisis respite.	Limit - 7 daysper stay, 21 days per year. PA not applicable. Billed daily. Bill U5 - reduced services modifier and HK modifier. Do not bill for transportati on .	No
7798	Intensive Crisis Respite	H0045	Respite Care Services, not in the home; per diem	HK	Per diem	1		Limit - 7 daysper stay, 21 days per year. Billed daily. Use HK modifier.	No
7799	Family Support and Training	H2014	Skills trainingand developmen t;per 15 minutes	HR or HS	Per 15 min	12		On-site or off-site.	Yes
7800	Family Support and Training (group of 2 or 3)	H2014	Skills trainingand developmen t;per 15 minutes	HR or HS, UN or UP	Per 15 min	12		On-site or off-site.	Yes
7801	Pre-vocational	T2015	Habilitation prevocation al ,waiver; per hour		Per hour	2	Only one employme ntservice per day.	Service mustbe one-to- one. Must comply with VP/IDEA restrictions.	Yes

RATE CODE	RATE CODE DESC.	PROC CODE	PROC.CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
7802	Transitional Employment	T2019	Habilitation, supported employmen t,waiver; per 15 minutes		Per 15 min	12	Only one employme ntservice per day.	Service mustbe one-to- one. Must comply with VP/IDEA restrictions.	Yes
7803	Intensive Supported Employment	H2023	Supported Employmen t	TG	Per 15 min	12	Only one employme ntservice per day.	Service mustbe one-to- one. Must comply with VP/IDEA restrictions.	Yes
7804	On-going Supported Employment	H2025	Ongoing support to maintain employmen t,per 15 minutes		Per 15 min	12	Only one employme ntservice per day.	Service mustbe one-to- one. Must comply with VP/IDEA restrictions.	Yes
7805	Education Support Services	T2013	Habilitatio n educationa l,waiver		Per hour	2		Service mustbe one-to- one. Must comply with VP/IDEA restrictions.	Yes
7806	Provider Travel Supplement (cost of staff travel to off-site service locations)	A0160	Non-emergency transportatio n : per mile - case workeror social worker		Per mile	60		Billing is at the recipient level. 56 cents (per Federal guidelines). Billed on a daily basis. See note 2.	

RATE CODE	RATE CODE DESC.	PROC CODE	PROC.CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
7807	Provider Travel Supplement (cost of staff travel to off-site locations - by subway)	A0160	Non-emergency transportation : per mile - case workeror social worker	U1	Per round trip	31	1st of the month billingonly.	Billing is at the recipient level. Bill monthly. Usefirst day of the month as the date of service.	
7810	1115 CORE Psychosocial Rehab-Employment Focus (On-site or Off-site)	H2017	Psychosocial rehabilitation services; per 15 min		N/A			Service must be one-to-one. Bill transportation supplement as appropriate.	
7811	1115 CORE Psychosocial Rehab-Education Focus (On-site or Off-site)	H2017	Psychosocial rehabilitation services; per 15 min	TF	N/A			Service must be one-to-one. Bill transportation supplement as appropriate.	

Mobile / Residential Crisis

RATECODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OFSERVICE
4609	Telephonic crisis response - Licensed (up to 90 min)	H2011	Crisis Intervention service, per 15 min	GT	6/Day
4610	Telephonic crisis response - Unlicensed (up to 90 min)	H2011	Crisis Intervention service, per 15 min	GT,HO	6/Day
4611	Telephonic crisis response - Licensed (above 90 min - 3 hours)	S9485	Crisis Intervention service, per diem	GT	1/Day
4612	Telephonic crisis response - Unlicensed (above 90 min - 3 hours)	S9485	Crisis Intervention service, per diem	HO	1/Day
4615	Mobile crisis response - 1 person response - Licensed (up to 90 min)	H2011	Crisis Intervention service, per 15 min	HE	6/Day
4616	Mobile crisis response - 2 person response - Licensed and Unlicensed/Certified Peer (up to 90 min)	H2011	Crisis Intervention service, per 15 min	HK	6/Day
4617	Mobile crisis response - 2 person response, both Licensed (up to 90 min)	H2011	Crisis Intervention service, per 15 min	HE,HK	6/Day
4618	Mobile Crisis Response (90 - 180 min) 2 person response - Licensed and Unlicensed/Certified Peer	S9485	Crisis intervention mental health services, per diem	HE,U5	1/Day
4619	Mobile Crisis Response (90 - 180 min) 2 person response, both Licensed	S9485	Crisis intervention mental health services, per diem	HE,HK,U5	1/Day

RATECODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OFSERVICE
4620	Mobile Crisis Response - Per Diem Requires a minimum 3 hours of face-to-face contact - 2 person response, Licensed and Unlicensed/Certified Peer	S9485	Crisis intervention mental health services, per diem	HE	1/Day
4621	Mobile Crisis Response - Per Diem. Requires a minimum 3 hours of face-to-face contact - 2 person response, both Licensed.	S9485	Crisis Intervention mental health service, per diem	HE,HK	1/Day
4613	Crisis follow up - face to face - 1 person response, Licensed (up to 90 min)	H2011	Crisis intervention service, per 15 min	TS,GT	6/Day
4614	Crisis follow up - face to face - 1 person response, Unlicensed/Certified Peer (up to 90 min)	H2011	Crisis intervention service, per 15 min	TS,HM	6/Day
4622	Crisis follow up - face to face - 2 person response, one Licensed and one Unlicensed/Certified Peer (up to 90 min)	H2011	Crisis intervention service, per 15 min	TS	6/Day
4623	Residential Crisis Support (RCS) - up to 28 days per admission	H2011	Crisis intervention, per diem	TS,HE	1/Day
4624	Intensive Crisis Residence (ICR) - up to 28 days per admission	H2011	Crisis intervention, per diem	TS,SC	1/Day
4625	Mobile crisis response - 1 person response - Licensed (up to 90 min)	T2034	Crisis Intervention service, per 15 min	HE	6/Day
4626	Mobile crisis response - 2 person response - Licensed and Unlicensed/Certified Peer (up to 90 min)	T2034	Crisis Intervention service, per 15 min	ET	6/Day

10. UTILIZATION MANAGEMENT

HCBS Service Descriptions, Level of Care Criteria, and CORE Services

- 1915i Home and Community Based Services Review Guidelines and Criteria
- Vocational Services
- Education Support Services
- Habilitation / Residential Support Services
- Community Oriented Recovery and Empowerment (CORE) Service Transition
- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Empowerment Services – Peer Support (Peer Support)
- Family Support and Training (FST)

1915i Home and Community Based Services Review Guidelines and Criteria

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders who are enrolled in the Health and Recovery Plan (HARP) 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, service providers, plan members and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and recover from serious mental illness and substance use disorders.

All HARP eligible members that consent will be linked to a local Health Home (HH) for care coordination. In addition any Medicaid member with a serious mental illness, HIV/AIDS or two chronic medical conditions can also receive Health Home support. Health Home care management is provided by the assigned community mental health agency. The HARP, in partnership with the HHs and HCBS providers, ensures medical and behavioral health care coordination and service provision for its members. The HARP will collaborate with Carelon Behavioral Health to oversee and support the Health Homes and HCBS providers via identified quality and utilization metrics and clinical review to ensure adherence with p r o g r a m specifications as defined by New York State established criteria. Carelon Behavioral Health in collaboration with the HARP utilizes a provider profiling tool that delivers programmatic data to both HHs and HCBS providers. This tool includes outcomes and compliance with HCBS assurances and sub- assurances. The HARP's 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 HARP enrollees.

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

These review guidelines provide a framework for discussion between HCBS providers and Plans. The review process is a collaboration between all pertinent participants including but not limited to the HH 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 member's 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.

HH care managers will determine eligibility for HCBS using a standard needs assessment tool. Procedures for authorizing specific HCBS include:

- The HH care manager will conduct a brief screening for HCBS eligibility with the member.

- If the member is eligible for HCBS the HH care manager will complete a full assessment that includes documentation of the member's needs, strengths, goals and preferences.

- In collaboration, the member and HH care manager will develop a comprehensive and person-centered Plan of Care. The Plan of Care will reflect the members assessed and self -reported needs as well as those identified through review claims and case conference with providers when appropriate.

- The HH care manager will share results of the HCBS assessment and Plan of Care with the Plan for review and feedback.

- If the member is enrolled with the HH, the HH will link the member with an HCBS provider; if the member is not enrolled with the HH, 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.

- HCBS Provider(s) will conduct service specific assessment(s) and forward additional information to HH care manager regarding intensity and duration of services. The HH care manager will update the Plan with HCBS provider specific information and present it to the MCO for review and approval.

- 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 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.

HH 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.

Vocational Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum and as such, Employment Support Services are grouped as a cluster and include Pre- vocational Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment. An appointment with Educational/Vocational or Employment Services should be offered to a member within two weeks of the request.

a) **Pre-vocational Services:** Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered plan of care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

b) **Transitional Employment (TE):** This service is designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive e m p l o y m e n t at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job- task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

c) **Intensive Supported Employment (ISE):** This service assists individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model. This service is based on Individual Placement Support (IPS) model which is an evidence based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not 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 activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

d) **Ongoing Supported Employment:** This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not 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 activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Education Support Services

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services may consist of general adult educational services s u c h as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program. Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes. An appointment should be offered within two weeks of request.

Habilitation/Residential Support Services

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and endure recovery, health, welfare, safety and maximum independence of the participant. Appointments should be offered within two weeks of the request.

Community Oriented Recovery and Empowerment (CORE) Service Transition

To improve access to these important rehabilitative services, NYS received federal approval to amend the 1115 MRT waiver to transition four BH HCBS to a new service array called Community Oriented Recovery and Empowerment (CORE) Services. These services are Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Family Support and Training (FST), and Empowerment Services – Peer Support (Peer Support). All other existing BH HCBS will remain available as BH HCBS with previously established requirements, workflows, and processes.

In line with the NYS regulatory changes, beginning February 1, 2022 NYS plans (HARPs, HIV SNPs, and Medicaid Advantage Plus {MAP}) may not conduct prior authorization or concurrent review for CORE Services for one year and until State notification.

Eligibility for CORE services is based on three criteria:

- The individual must be HARP Eligible,
- The individual must be enrolled in a HARP or HIV-Special Needs Plan (SNP); and
- The services must be recommended by a Licensed Practitioner of the Healing Arts (LPHA).

CORE providers must notify Carelon Behavioral Health within three (3) days after the first date of initiating a new CORE service.

NYS developed a 'service initiation template' containing information providers must submit to Carelon Behavioral Health. This form may be found at Community Oriented Recovery and Empowerment (CORE) Service Initiation Notification Form-4/1/2024 (ny.gov).

CORE Services may be provided in combination with a variety of BH HCBS and State Plan services. Refer to the allowable services charts in the Benefit and Billing Guidance Community Oriented Recovery and Empowerment Services Benefit and Billing Guidance (ny.gov)

If the enrollee is receiving a duplicative service the MCO should initiate a person-centered discussion between the enrollee, their providers, and their care manager (when applicable) to determine which service or program is the most appropriate for their needs. The MCO is responsible for communicating with the enrollee and providers, in writing, the outcome of the person-centered discussion and the enrollee's decision regarding which services will continue.

Psychosocial Rehabilitation (PSR)

Psychosocial Rehabilitation (PSR) is designed to assist an individual in improving their functional abilities to the greatest degree possible in settings where they live, work, learn, and socialize. Rehabilitation counseling, skill building, and psychoeducational interventions provided through PSR are used to support attainment of person-centered recovery goals and valued life roles. Approaches are intended to develop skills to overcome barriers caused by an individual's behavioral health disorder and promote independence and full community participation.

Community Psychiatric Support and Treatment (CPST)

Community Psychiatric Support and Treatment (CPST) includes goal-directed supports and solution-focused interventions with the intent to achieve person-centered goals and objectives. This is a multi-component service that consists of therapeutic interventions such as clinical counseling and therapy, which assist the individual in achieving stability and functional improvement. CPST addresses behavioral health barriers that impact daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community participation. CPST is designed to provide mobile treatment services to individuals who have difficulty engaging in site-based programs, or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment. CPST allows for delivery of services within a variety of permissible of-site settings including, but not limited to, community locations where the individual lives, works, learns, and/or socializes.

Family Supports and Training (FST):

Family Support and Training (FST) offers instruction, emotional support, and skill building necessary to facilitate engagement and active participation of the family in the individual's recovery process. The FST practitioner partners with families through a person-centered or person-directed, recovery oriented, trauma-informed approach. Family is defined as the individual's family of choice. This may include persons who live with or provide support to a person, such as a parent, spouse, significant other, children, relatives, foster family, in-laws, or others defined as family by the individual receiving services. Family does not include individuals who are employed to care for the individual receiving services.

Empowerment Services – Peer Support

Empowerment Services – Peer Support (Peer Support) are non-clinical, peer-delivered services with focus on rehabilitation, recovery, and resilience. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural supports and community resources. Peer Support must include the identified goals or objectives in the individual's ISP, with interventions tailored to the individual. These goals should promote utilization of natural supports and community services, supporting the person's recovery and enhancing the quality of their personal and family life. The intentional, goal-directed activities provided by this service emphasize the opportunity for peers to model skills and strategies necessary for recovery, thereby developing the individual's skills and self-efficacy. These services are provided through the perspective of a shared personal experience of recovery, enhancing the individual's sense of empowerment and hope.

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	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	No	N/A	Non-urgent appointments should offered within two to four weeks of request.
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill 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.

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
Personalized Recovery Oriented Services (PROS) Admission: Individualized Recovery Planning	No	No	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.
Mental Health Continuing Day Treatment (CDT)	Yes	Yes	Appointment should be offered within two to four weeks of request
Mental Health Intensive Outpatient (note: NOT State Plan)	Yes	Yes	Appointment should be offered within one week of request
Mental Health Partial Hospitalization	Yes	Yes	
Assertive Community Treatment (ACT)	No	No	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	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.
Medically Supervised Outpatient Substance Withdrawal	No	No	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.
Opioid Treatment Program (OTP) Services	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
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.

For substance use disorder facilities in NYS in-network, OASAS licensed providers, inpatient and residential services require notification of admission within two business days from admission. The decision to provide treatment or service to a member is the responsibility of the attending provider and the member (his or her patient).

Effective January 1, 2017, New York State OASAS licensed in-network providers must provide official "Notice of Admission" (NOA) for all Substance Use Disorder Services. This notification allows a provider to treat a member for a standardized amount of time, or until their discharge (whichever occurs first), without a preservice or concurrent medical necessity review. Carelon may request a medical necessity review upon discharge or after the standardized amount of time (whichever occurs first). Per NYSUD legislation, the member will be held harmless.

As of January, 1, 2020 the legislation has been expanded to allow the first 28 calendar days of treatment services (not to exceed 28 treatment days) to be covered upon notification of admission, provided the notification was received within 2 business days of admission.

The process applies to members covered by Child Health Plus, Commercial, Essential, and Medicaid Managed Care plans.

Out-of-network providers and notifications received later than 2 business days will follow standard UM processes.

The NYSLOCATDR 3.0 tool with be used for level of care determination for OASAS services. The LOCADTR tool is available online at:
https://extapps.oasas.ny.gov/locadtr/index.php

On January 1, 2020 New York State regulatory requirements changed for behavioral health utilization review. This legislation prohibits prior authorization of inpatient mental health services delivered by an in-network, Office of Mental Health (OMH) licensed facility to members under the age of 18.

Carelon implemented a Mental Health Notice of Admission (NOA) on all Health Plan and City of New York business. The NOA process will be available for all in network New York providers who complete the notification within two business days of admitting a member to one of the levels of care noted. Upon notification, providers will receive authorization as follows:

- For adults (18 years old and over):
    - IOP: 15 business days
    - PHP: 10 business days
    - Inpatient Mental Health: 9 calendar days
- For children (17 years old and under)
    - IOP/PHP: 14 business days
    - Inpatient Mental Health: 14 calendar days

In-network, New York providers who do not complete the notification within 2 business days of a member admission, as well as out-of-network providers will be subject to the standard telephonic review process. The number of days initially allowed under the NOA were determined based on current average length of stay benchmarks across New York State for their respective levels of care. Although the services continue to be subject to medical necessity, review can only occur retrospectively after discharge (or after the initial authorization time period has passed, whichever comes first), and/or concurrently after the initial authorization time period.

Effective 10/01/21 to ensure clinically appropriate and parity compliant coverage, as well as provide additional discharge planning and care management support. Providers are required to notify Carelon of admission within two (2) business days via the NOA process; providers who do not complete the notification within two (2) business days of a member admission will be subject to the standard telephonic review process. Carelon will only conduct utilization review for acute services (inpatient or partial hospital programs) for members who meet the following clinical criteria:

- Individuals subject to a current Assisted Outpatient Treatment (AOT) court order
- Individuals who had an AOT court order that expired within the past five years

- Individuals with high utilization of inpatient or emergency department (ED) services in the past year as evidence by:
    - Three (3) or more psychiatric inpatient hospitalizations in the prior 12 months; OR
    - Four (4) or more psychiatric ED visits in the prior 12 months; OR
    - Three (3) or more medical inpatient hospitalizations in prior 12-months;
- Individuals who are readmitted to any mental health inpatient unit within thirty days of discharge from a prior mental health inpatient admission; or
- Individuals not meeting any of the above triggers whose length of stay exceeds 30 days. In these cases, Carelon will apply concurrent review from Day 31 onwards but will not apply medical necessity criteria or issue denials for any of the first 30 days.

This update only applies to mental health services; PHP, MH Residential, and Inpatient (not Obs) level of care are affected and to any provider in New York State both INN and OON. Providers out of state are not affected and for them it is business as usual. No changes to lower levels of care. Utilization management processes for SUD remain unchanged. Changes apply to members of all ages, though 14 days still guaranteed for children admitting to an INN provider. Within two (2) business days, providers will be made aware of whether a member meets clinical criteria requiring medical necessity review. This process applies to members covered by Medicaid, Commercial, and Exchange lines of business, not Medicare.

11. QUALITY MANAGEMENT/QUALITY IMPROVEMENT

HARP Committee Structure

In addition, Carelon and its health partners maintain committees such as the Medicaid Behavioral Health HARP Quality Management (BHHQM) Subcommittee that provide oversight, guidance, and ongoing performance monitoring for the HARP and QHP products. The committee meets on a quarterly basis and includes participation of members, peers, peer specialists and provider representatives in an advisory capacity to inform the design and implementation of key quality, UM and clinical initiatives.

For questions on how to join and participate in our committees, please contact Carelon

12. ADDITIONAL HELPFUL RESOURCES

Attachment 1

Ambulatory mental health services for adults for which Mainstream Managed Care andHealth and Recovery Plans may require prior and/or concurrent authorization of services

Service	Prior Auth	Concurrent Review Auth	AdditionalGuidance
Outpatient mental health office and clinic services including: initial assessment; psychosocial assessment; and individual, family/collateral, and group psychotherapy	No	Yes	MMCOs/HARPs must pay for at least 30 visits per calendar year without requiringauthorization. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCO/HARP; b) off-site clinic services; or c) psychiatric assessment and medication management visits. Multiple services received on thesame day shall count as a single visit (and must be delivered consistent with OMHclinic restructuring regulations: http://www.omh.ny.gov/omhweb/clinic_restructuring/part599/part-599.pdf
Outpatient mental health office and clinic services: psychiatric assessment;medication treatment	No	Yes	
Outpatient mental health office and clinic services: off-site clinic services	Yes	Yes	OMH will issue further guidance regarding off-site clinic services.
Psychological or neuropsychological testing	Yes	N/A	
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit.
PROS Admission:Individualized Recovery Planning	Yes	No	Admission begins when ISR is approved by Plan. Initial Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for Clinical Treatment, Intensive Rehabilitation (IR), or Ongoing Rehabilitation and Supports (ORS). Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers
Mental Health Continuing Day Treatment (CDT)	Yes	Yes	
Mental Health Intensive Outpatient (note: Not State Plan)	Yes	Yes	
Mental Health Partial Hospitalization	Yes	Yes	
Assertive Community Treatment (ACT)	Yes	Yes	New ACT referrals must be made through local Single Point of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations ofeligibility and appropriateness for ACT following forthcoming NYS guidelines.

Service	Prior Auth	Concurrent Review Auth	AdditionalGuidance
OASAS-certified Part 822 clinic services, including off-site clinic services	No	Yes	See OASAS guidance regarding use of LOCATDR tool to inform level of caredeterminations. OASAS encourages plans to identify individual or program service patterns thatfall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization; 30-50 visits per year are within an average expected frequency for OASAS clinic visits. The contractor will allow enrollees to make unlimited self-referrals for substance use disorder assessment from participating providers without requiring prior authorization or referral from the enrollee's primary careprovider. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.
Medically supervised outpatient substance withdrawal	No	Yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame.
OASAS Certified Part 822 Opioid Treatment Program (OTP) services	No	Yes	OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization; 150-200 visits per year are within an average expected frequency foropioid treatment clinic visits. The contractor will allow enrollees to make unlimitedself-referrals for substance use disorder assessment from participating providerswithout requiring prior authorization or referral from the enrollee's primary care provider. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.
OASAS Certified Part 822 Outpatient Rehabilitation	No	Yes	Plans may require notification through a completed LOCADTR report foradmissions to this service within a reasonable time frame. The contractor will allow enrollees to make unlimited self-referrals for substanceuse disorder assessment from participating providers without requiring prior authorization or referral from the enrollee's primary care provider. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.

Attachment 2

Carelon Behavioral Health

New York Level of Care Clinical Criteria

Click here to access the New York Level of Care Clinical Criteria